

# TOWARDS AN UNDERSTANDING OF DIVERSITY

A  
*constructivist response  
to the challenge  
of  
cross-cultural psychology*

By  
*Joanne Thakker*

A thesis submitted in fulfilment of the requirements for the degree of  
Doctor of Philosophy in psychology.

*Department of Psychology  
The University of Canterbury*

*1997*

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## ACKNOWLEDGEMENTS

Thank you firstly to Dr Tony Ward and Professor Ken Strongman for their excellent supervision and much needed encouragement. Thanks also to Russil for the many illuminating discussions which contributed enormously to my understanding of a number of topics. A special thank you to my parents for their ongoing support and for baby sitting on so many occasions. And finally I must thank my children Sanjay and Anjali for tolerating my absence.

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# *ABSTRACT*

The Western approach to understanding mental disorder, as indicated in the Diagnostic and Statistical Manual of Mental Disorders, is based on a bio-medical perspective which sees mental disorders as 'natural kinds' or discrete entities which manifest as dysfunction within individuals. Following from this is the view that its primary syndromes are ubiquitous world-wide, based on the assumption that this dysfunction is similar across diverse human populations. However, the cross-cultural literature reveals significant differences in the manifestation of these syndromes across ethnic groups, thereby challenging the universalist position. In response to this shortcoming, of the predominant contemporary conceptualisation of mental disorder, a constructivist understanding is offered which, it is argued, has a number of important advantages over the traditional view. In particular, a constructivist view can acknowledge the important role of social factors in the manifestation of mental disorder. And, importantly, it lends itself to a variety of alternative approaches to diagnosis and treatment which are culture-sensitive, and which therefore may prove advantageous in cross-cultural clinical contexts.

# INTRODUCTION

The study of mental disorders goes back centuries yet it was not until about 30 years ago that their manifestations across cultures received serious attention. Earlier studies, of which there were only a handful, were strongly influenced by racial prejudice with many seeking only to confirm the assumed superiority of Western Caucasian peoples (e.g. Carothers, 1951 & Smartt, 1956). But while the past three decades of research have yielded some interesting findings there is much that remains to be discovered and understood. One of key questions in the area of cross-cultural psychology is to what extent mental disorders are contingent on biological factors on the one hand and socio-cultural factors on the other. This question is reminiscent of the 'nature verses nurture' debate which has fascinated psychologists for years. But notably psychologists are no longer interested in which of these factors is more important, but in understanding the complex interaction between them. Human development involves a dynamic process wherein biology and sociology come together in the emergence of various characteristics and abilities.

It will be argued herein that within the fields of clinical psychology and psychiatry, this interaction and interconnection has been largely overlooked. Mental disorders are typically viewed as socio-environmentally impenetrable, with too much attention paid to the bio-medical dimension of mental disorder. This traditional view is exhibited in the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in its definition of mental disorder and in its general format. This has implications both for the treatment of psychopathology and for research. For example if schizophrenia is viewed as essentially biological in nature then there is a greater tendency to use psychopharmacological treatments and to ignore the socio-cultural context of the condition. And with regard to research, there has been an emphasis on the search for cross-cultural universals based on the view that all human beings are physiologically equivalent.

I will argue that the prima-facie acceptance of the bio-medical approach to the understanding of psychopathology is problematic in light of the cross-cultural findings which demonstrate that mental disorders vary significantly, in their clinical manifestations, across cultures. While the DSM-IV has attempted to extend its scope by acknowledging cultural factors, it is impeded by notions of biology and associated ubiquity which are at this time highly speculative. Research in this area has been greatly influenced by the views of general medicine which rely on the disease model of illness - a model which is arguably, out of place within psychology. While medical research has made and continues to make a significant contribution to the understanding of psychopathology, this must be coupled with social analysis in order to provide a balanced and complete understanding of the field.

As mentioned, the focus of the discussion is the cross-cultural manifestation of mental disorder. This focus serves to highlight and exemplify the problems with the traditional bio-medical understanding of mental disorder. The DSM-IV assumes that its primary disorders are universal in contrast to the list of culture-bound syndromes provided in an appendix. Western disorders are given a different status, but this is not only because it is intended for use among Westerners. Rather the DSM is used in a variety of ethnic environments and there is an assumption that the primary disorders are actually ubiquitous phenomena. However as will be shown herein this is yet to be established. There are some very important cross-cultural differences in the presentation of disorders such as depression and schizophrenia which challenge the traditional view.

In response to these difficulties I introduce constructivism as an alternative conceptual framework for the understanding of mental disorder - alternative to the traditional bio-medical model. Constructivism emphasises the interpersonal context of human experience and behaviour, hence it can acknowledge and explain cross-cultural diversity. Constructivism is used as an alternative conceptual approach, yielding a number of important proposals and implications for the development of more culture-sensitive clinical and research practices. The purpose of this application is to consider the various ways in which an alternative conceptual framework may impact on the understanding of mental disorder generally and the understanding of its cross-cultural dimensions in particular.

As shown in the contents, the chapters are grouped in three parts. Part one looks at the contemporary approach to the understanding of mental disorder. The first chapter discusses the definition of mental disorder, paying particular attention to the definition provided in the DSM IV and chapter two examines the process of classification, once again focusing on the DSM IV, with a detailed analysis of its theoretical foundations. The aim in these first two chapters, which comprise part one, is to outline and explicate the prevailing approach to the understanding of mental disorder and to identify its limitations.

Part two consists of four chapters which cover the cross-cultural literature. Chapter three looks at the history of cross-cultural psychology, showing in particular the various factors which have been influential throughout its development. The following chapter brings the analysis up to date with a comprehensive discussion of contemporary issues, sketching the breadth of the field, and providing some examples of the interface between culture and mental disorder. Chapter five examines the cross-cultural application of the DSM IV including an analysis of the recent culture-oriented modifications, a study of some of its so-called culture-bound syndromes, and lastly a look at the cross-cultural manifestation of depression. Chapter six, which is the final chapter in this section, provides a detailed discussion of schizophrenia across cultures.

Part three presents a constructivist approach to mental disorder beginning with chapter seven which introduces constructivism by way of an historical narrative, looking chronologically at the various theorists who have been influential in its emergence. Chapter eight offers a constructivist definition of mental disorder and chapter nine discusses the implications of this definition for classification, diagnosis and treatment. And finally chapter ten looks at the implications for research and presents a brief evaluation of the constructivist approach.

# *PART ONE*

## *THE CONTEMPORARY APPROACH TO THE UNDERSTANDING OF MENTAL DISORDER*

# CHAPTER 1

## WHAT IS A MENTAL DISORDER?

As indicated this opening chapter will discuss the definition of mental disorder. While this definition may seem apparent and straightforward, as the following explication will demonstrate, it is neither of these. Many people would probably respond quite spontaneously to the above question with comments such as, “a sickness of the mind”, or “that which afflicts people who are in mental hospitals”, “what some people have who behave strangely” or perhaps “a disorder of the brain” or simply “insanity”. Combined, these ideas make up the many-faceted lay concept of mental disorder with which most of us are familiar. Within this lay concept are a number of important elements which can also be seen in more formal discussions of the definition. For example the idea that a mental disorder involves a dysfunction in the brain and that it involves behaviour which is outside the range of what is considered ‘normal’. Also important is society’s response to the phenomenon which may be to put the mentally disordered individual in an institution.

Central to this discussion is the question of whether mental disorders are essentially physiological or social or both. If they are simply a matter of social value then one would expect them to vary significantly across cultures according to the diverse manifestation of socio-cultural beliefs, values and traditions. If on the other hand they are the result of physiological dysfunction then there may be striking similarities in their presentation across many different social groups.<sup>1</sup> While the relevant empirical literature will be evaluated later, it is important at the outset to discuss the definition of mental disorder and to look in particular at contemporary definitions which have been

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<sup>1</sup> For the purposes of this introductory discussion, this point has been simplified and hence it requires qualification. Firstly as will be noted in detail later, there may be physiological variation between ethnic groups meaning that a physiological element will not necessarily denote universality. And secondly social factors should not be seen as divorced from physiological ones but rather as interacting with them.

and continue to be influential in this area. Hence this chapter will discuss in detail the definition found in the latest edition of the DSM (American Psychiatric Association [APA], 1994) and the definition provided by Wakefield which has received widespread support.

'Mental disorder' is today the term of choice for psychological disturbances. In the past there have been others such as 'mental illness' and 'mental disease' which imply a breakdown of psychological systems which is analogous to the disruption or disease of biological systems (Reber, 1985). This approach relies on the idea that most mental problems could be traced back to a particular point of malfunction which would be similar to the lesion or germ of the 'medical model'. The malfunction would bring about some type of systemic failure and this would result in psychological symptoms. 'Mental disorder', on the other hand, is believed to be more neutral in this regard (Reber, 1985). The notion of disorder carries fewer misleading connotations. It has no special affiliation with the 'biological' or 'medical' approach or with any other particular position.

While the notion of 'disorder' is relatively straightforward in that it carries little conceptual baggage, the concept of 'mental' is more problematic. It unfortunately suggests a distinction between disorders which are 'mental', and disorders which are 'physical' as if the two categories are mutually exclusive ( Reber, 1985; APA 1994 ). Arguably each arena impinges on the other; many physical problems are believed to be affected by psychic phenomena and many psychological problems are believed to have a physiological component. For example hypertension and heart disease are two medical conditions which are believed to be influenced by mental states (Schneiderman, Chesney & Krantz, (1989). And likewise dementia is a psychological condition which is associated with neural damage. It is stated in the DSM IV that the primary reason that the term 'mental' has endured is because no adequate substitute has been found.



## *THE DSM-IV DEFINITION*

The DSM-IV, which is today the most widely used Western diagnostic and classificatory system (Maser et al., 1991), provides a multifaceted definition of mental disorder. By way of elucidation and perhaps justification of this approach, it sites examples of somatic disturbance, all of which are recognised medical conditions, but none of which are alone, entirely representative of the concept of physical disorder. For example some physical ailments are manifested simply as subjective distress ( e.g., migraine ) while some occur as structural damage ( e.g., tumour ). Others such as hypertension are measured in terms of deviation from a prescribed norm.

Similarly mental disorders, can occur in many forms, and involve different criteria for abnormality. The DSM-IV (APA, 1994) lists a number of criteria of psychological abnormality including: distress, disability, etiology and statistical deviation. Considering the diversity of these concepts it is difficult to produce a definition of mental disorder which incorporates all presentations. The definition given in the DSM-IV reflects the variation in mental disorder, stating explicitly the aspects of psychological functioning which may be affected. The key elements of the DSM-IV definition are as follows:

...each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual...(American Psychiatric Association (APA), p xxi).

This definition has remained relatively unchanged since its original appearance in the DSM-III. The central criteria of the definition are the notions of distress, disability, expectability and dysfunction. The concept of distress captures the more subjective and experiential aspects of mental disorder while the concept of disability has a closer affiliation with things behavioural or observable. These two concepts, which

incidentally should not be interpreted as mutually exclusive groups, capture two important domains of psychological pathological phenomena. These are, instances of subjective experience, such as thoughts and feelings, and instances of overt behaviour, such as tremors (e.g. in Parkinson's disease) and catatonic withdrawal (e.g. in schizophrenia). Conceiving of these psychological realms as relatively distinct, provides a useful way of understanding psychological symptoms; some disorders will involve one area of functioning more than the other while some might involve each equally. Of course disability will usually have an experiential element; most disorders involve some degree of subjective modification and mental disorders are after all, disorders of the psyche. The distinction is useful however in that it acknowledges that psychological impairment may be purely experiential or purely behavioural or both.

Another significant part of the definition is the concept of expectability. This is construed in terms of statistically determined norms. Anything unexpected will be that which is statistically speaking, unlikely, and therefore outside the range of 'normal' phenomena. Wakefield (1992) has been highly critical of this criterion of abnormality. The problem with such an analysis, he says, is that many statistically unexpected conditions are functionally normal and many expected conditions are not. He cites the example of anaclitic depression which arises from a lack of contact with a caregiver during infancy. Considering the circumstances, such a response is expectable and yet it is nonetheless a disorder. Similarly, chronic depressed mood which also appears as a disorder in the DSM-IV can also in some contexts be expected; for instance, when it occurs in response to sexual abuse.

Describing mental disorder as deviation from statistical normality fails to capture the essence of the concept and moreover adds yet another indeterminate expression to the discussion. As Wakefield rightly points out, something that is unexpected or unusual is not necessarily abnormal. In certain extreme environmental conditions, dysfunction such as that evidenced in post-traumatic stress disorder could reasonably be expected and within a sub-group of the population such as veterans of war these sorts of symptoms could be quite common. If the concept of expectability is to be used effectively in the definition of mental disorder, it, itself, will require clarification. As mentioned above, in particular populations, some disorders can be likely, which would

he unlikely in the wider community. It is not clear whether discrimination between a sub-group and the wider population is allowable according to the DSM-IV definition.

The other important component of the DSM's definition is the notion of dysfunction which may be 'behavioural, psychological or biological'. Dysfunction is, according to the Oxford English dictionary (1991) "an abnormality or impairment of function". In other words it denotes a breakdown or disruption of a system wherein the system fails to perform as it would ordinarily. The term dysfunction then, suggests that something has 'gone wrong' within the organism. This conception of mental disorder is consistent with the medical model wherein mental disorders are construed as diseases requiring diagnosis and treatment (Blashfield, 1984) just as purely physical conditions are. According to Blashfield, the medical model has had a powerful influence on contemporary understandings of mental health. This influence has been reflected in the various DSMs which list a variety of discrete diagnostic entities each of which is associated with a particular treatment approach. This conceptualisation of psychopathology is rooted in the notion of dysfunction which denotes a specific disease or breakdown within the organism.

The DSM definition of mental disorder relies on the notion of dysfunction to provide an objective 'scientific' means of identifying psychopathology (Klein, 1978; Thakker & Ward, in press; Wakefield, 1992). In this way a mental disorder may be distinguished from a purely socio-culturally or perhaps socio-politically motivated label. So while the DSM-IV acknowledges the influence of culture in its definition, it states that mental disorder is not solely a matter of social judgement. As noted by Wakefield (1997) this aspect of the definition is intended to prevent the use of labels of psychopathology for the purposes of social control. It is not sufficient that society expresses disapproval of a particular behaviour through the application of a diagnostic label. Rather, there must be a problem within the individual which interferes with his or her ability to function.

But importantly the social dimension of disorder is also acknowledged by the latest DSM. Included in the definition is the phrase, 'culturally sanctioned' referring to psychological disturbance which is, for whatever reason, accepted by society. Within the definition this phrase is linked with the term expectability, conveying the view that

psychological anomalies which are accepted or expected in one culture may not be in another. This is indicative of the general acknowledgement of the influence of culture on at least some aspects of some of the disorders which are listed in the diagnostic and statistical manual.<sup>2</sup> Illustrating this point the DSM gives the example of grief which may be characterised by an extreme emotional response but is not considered a mental disorder. This is because it is a culturally accepted response to 'the death of a loved one'. So mental states or behaviours which are unusual or excessive are not necessarily signs of mental disorder. Rather they must be evaluated in terms of their context, including their relation to significant life events and socio-cultural environment.

The acknowledgement of a social aspect of mental disorder seems inconsistent with the idea that mental disorder involves intra-organismic dysfunction. If such dysfunction exists then social judgement may be seen as irrelevant with regard to the demarcation of psychopathology. According to Kleinman (1988) this apparent inconsistency can be explained with a reductionistic conceptualisation wherein dysfunction is seen as the basis or heart of mental disorder and social factors are seen as variables which intrude peripherally - subtly changing symptoms and perhaps influencing the way in which the symptoms are explained in various social groups.<sup>3</sup>

### *SOME ALTERNATIVE ANALYSES*

Considering the importance of the term 'mental disorder' in the diagnostic process and its theoretical underpinnings, it is surprising that few theorists have analysed it. Spitzer (the primary editor of the DSM-III and DSM-IV) and Endicott (1978) made a significant contribution to the field with their attempt at an operational definition. In breaking down the concept of disorder, which was used in connection with both physical and mental conditions, they identified a number of key elements, the most fundamental and problematic of which was the term 'dysfunction'. The analysis which ensued was therefore focused primarily on the operationalisation of this concept. The

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<sup>2</sup> The DSM's approach to the social dimension of mental disorder will be examined in detail in chapter five.

<sup>3</sup> This conceptualisation will be discussed in detail in chapter 4.

main criteria of Spitzer and Endicott's definition of 'organismic dysfunction' are as follows:

1. Distress- acknowledged by the individual or manifested.
2. Disability- some impairment in functioning in a wide range of activities.
3. Disadvantage- certain forms of disadvantage to the individual in interacting with aspects of the physical or social environment because of an identifiable psychological or physical factor.
4. The controlling variables tend to be attributed to being largely within the organism with regard to either initiating or maintaining the condition.

(Selected excerpts from Spitzer and Endicott, 1978, pp 2~21 ).

The term 'distress' refers to the discomfort which is experienced by the individual and as noted above can be ascertained according to subjective or overt data. Like the DSM-IV definition this criterion captures the experiential information. The second criterion - disability - which is described as 'impairment in functioning' is similar to the third factor of disadvantage which is construed in terms of problematic interaction with the environment. The last factor is elaborated in the original excerpt with such words as 'atypical' and 'impairment', conveying the idea that the condition is due to some sort of malfunction. Disability can also be incorporated under this conceptual umbrella as this also is described in terms of systemic failure. The fourth criterion simply says that the disorder must be a problem of the individual and not a problem of the environment. So, with regard to either the onset or maintenance of the problem, it must stem from within the person.

To summarise then, a dysfunction is understood by Spitzer and Endicott to be a disruption of functioning, which occurs within an individual and which is evidenced as either distress, disability or disadvantage (or combinations of all three). So it may involve the disruption of psychological functioning or behavioural or both.

In a comprehensive analysis of Spitzer and Endicott's definition of dysfunction, Wakefield (1993) both commended and criticised aspects of their work. Wakefield appreciated the detail which their definition provided, which sought to incorporate the

many different ways in which a dysfunction might arise but he noted that such detail also brought about restrictions meaning that the definition was not fluid enough to capture all instances. The detail in question which included statements such as, "lack of ability to reproduce" and "marked impairment in the ability to form relatively lasting and non-conflictual interpersonal relationships", (Spitzer and Endicott, 1978, pp20-21), introduced a precise delineation between a disorder and a non-disorder. This precision proved problematic and Wakefield presented a number of powerful counter-examples which clearly showed the inadequacies of this particular operational approach. In fact, Wakefield believes that any operational approach would fail because of the nature of the concept (dysfunction). Dysfunction he says, is a theoretical concept which is only loosely related to particular internal mechanisms. These mechanisms are more often inferred than observed, meaning that little might be known about the detail of their operations. Hence an operational definition is difficult, if not impossible. It seems apt, as Wakefield suggests, to leave this sort of detail to the description of particular disorders.

At the heart of Spitzer and Endicott's definition is the concept of malfunction or functional impairment, a focus which Wakefield sees as the definition's main drawcard. This concept is demonstrated by terms such as disadvantage and disability; suggesting some sort of interference with the usual order. However although they give examples of the disturbance of this order, they fail to clarify its nature. The order in question is quite simply, normality. Spitzer and Endicott offered no definite criteria of normality meaning that terms such as disability were less informative than they might otherwise have been. A disability is described by Spitzer and Endicott as impairment of a particular system or structure and this impairment must simply be construed in contrast to the way in which the system usually functions.

For Wakefield the 'usual' way is that which has been developed by the process of natural selection; that which over the years has proved advantageous and has therefore enhanced survival. So, rather than elaborating on the idea of normal and abnormal functioning by giving detail of diverse instances, Wakefield prefers a theoretical approach presenting the theory of evolution as a foundation for understanding normalcy and deviation from this normalcy.

Wakefield expands the work of Klein (1978) who presented a similar approach to the definition of mental disorder, relying heavily on biological processes. When discussing this topic Klein uses the term 'mental illness' conveying the view that mental disturbance is simply a subset of other physically based illnesses. Klein's use of this concept is intimately connected with his emphasis on "involuntary impairment", which is seen to play a key role in his definition. According to Klein, a functional disturbance of the kind evident in mental disorder is entirely unintentional and uncontrolled in the same way that physical disturbance is. Klein sees this as vital to the general conception of mental illness whereby people who are given this label are often excused for actions which are harmful or socially inappropriate. Illness, whether it be physical or mental is understood by Klein as deviation from evolutionally determined norms. Normal biological function, on the other hand, is that which conforms to evolutionally prescribed standards. These standards are the result of natural selection which of course has the goal of maximising reproductive fitness. So, mental illness is something which stands in the way of this process; something which disrupts biological systems and inhibits reproductive success.

The demands of the functional definition appear less rigorous than those of the operational one; we can look at the role or function of a particular behaviour within the context that it originated without having to determine its intricacies; the intricacies being the detail of its operational systems. The function of a mechanism can be determined even if the mechanism itself evades detailed inspection.

Like Klein, Wakefield presents the view that mental mechanisms, like physical ones, are products of natural selection. Mechanisms which promote fitness are more likely to be passed on to successive generations and hence to survive and develop over time. Mental mechanisms which we all utilise today are products of this lengthy selection process. A problem with one or other apparatus can be described in terms of its deviation from this evolutionally developed norm. So, according to Wakefield a dysfunction is said to occur when a mechanism fails to perform its natural (evolutionally designed) function. The notion of function is vital to Wakefield's definition. Using an analogy with artefacts, such as chairs, he says, "...the function

explains why the artefact was made, why it is structured the way it is, why the parts interact the way they do, and why we can accomplish certain things with the artefact”, (1992a p 382). According to Wakefield much can be learnt about a mechanism by looking at its function. For instance the main function of a chair is for sitting. The function explains why chairs are designed in particular ways; by understanding the function of chairs we can determine what it means for a chair to be normal and functional and according to this we can determine what would be classed as a malfunction or impairment of that function. Wakefield believes that functional explanations have tremendous explanatory power; by understanding the function of a particular mechanism we can gain insight into its developmental history and its current state.

In contrast to Klein, whose definition of mental disorder (mental illness) is dominated by the notion of physiological dysfunction, Wakefield’s definition attributes equal significance to the social realm. He defines mental disorder as “harmful dysfunction” (Wakefield 1992a & 1992b), wherein harm is ascribed according to societal standards. In order for a problem to demand the label of disorder it should not only interfere with natural functioning, but also cause this sort of harm. To illustrate the relevance of this notion, Wakefield describes a physical condition called albinism which is a reversal of heart position. This condition which is clearly a deviation from the norm - a norm which is set by nature - does not actually have any apparent negative effects. It would be inappropriate, therefore to call this a disorder because although it is clearly abnormal in the statistical sense, it is not a problem.

Similarly a person who presents with mania may not view the condition as problematic. Although a condition might appear to be deviant in terms of what is 'normal' or 'natural' according to biologically determined standards, it would not be called a disorder unless there is some degree of harm. Wakefield says that only dysfunctions which are “socially disvalued” are disorders. For instance last century there was a disorder referred to as ‘drapetomania’, which was said to afflict slaves who escaped from their masters. Along with this Wakefield gives a number of other equally absurd examples (at least they seem so now), all of which highlight the significance of value judgements in the perception and understanding of mental disorder. So Wakefield’s construal of the



'harm' criterion is purely social; a problem will only be described as harmful if it is socially undesirable. If catatonia is a state which is viewed as desirable by a particular community then it will not be classed as a condition worthy of treatment; it will not therefore be described as disordered.

A disorder then, for Wakefield, involves the disturbance of both biological and social order. He succinctly states: "A disorder exists when the failure of a person's internal mechanisms to perform their functions as designed by nature impinges harmfully on the person's well-being as defined by social values and meaning" (1992a, p. 373). These two components are believed by Wakefield to be both necessary and sufficient for mental disorder. This to date, is one of the most comprehensive analyses of mental disorder and it is for this reason that it is being discussed herein, in detail. Although many other theorists have been critical of contemporary definitions, few have attempted like Wakefield, to provide viable alternatives. Another important reason for discussing it is that it is very similar to the DSM definition of mental disorder in that it combines the notion of dysfunction with a social component. However Wakefield extends and explicates this approach through the presentation of an evolutionary/biological perspective.

The main strength of Wakefield's definition lies in the inclusion of both biological and social dimensions. He states that, "a disorder lies on the boundary between the given natural world and the constructed social world" (1992a, p. 373). A disorder or "harmful dysfunction" occurs when both of these dimensions are disturbed. Only a disruption of functioning which results in socially disvalued experiences or behaviours will be called a disorder. Most of the criticisms which follow refer not to this aspect of the definition but rather to the reliance of the concept of dysfunction to demarcate mental disorder. Hence much of the critique which is directed at Wakefield's definition applies also to the definition given in the DSM-IV.

## *A CRITIQUE OF WAKEFIELD*

There are a number of problems with Wakefield's definition. Firstly mental disorders are not obviously the result of a breakdown of evolutionally designed mechanisms. Rather some are arguably associated with adaptive responses. For instance PTSD may be in part due to the normal functioning of adaptive mechanisms. The stressful life event which is believed to play a key role in the development of the condition is typically a dangerous one, often with the threat of death. Such an event is not easily forgotten and in the case of PTSD there are recurring thoughts and images and intense anxiety in response to situations which evoke memories of the event. That people are often hypervigilant and very sensitive to cues which they associate with the stressful event, could be seen as adaptive. Perhaps they would respond more quickly to a similar danger. Such individuals often experience a rush of adrenaline during periods of anxiety which may be useful in confronting or avoiding danger.

Similarly dissociative identity disorder (previously known as multiple personality disorder), a rare disorder which is typically linked to traumatic experiences during childhood may also be viewed as adaptive. It is possible that the process of splitting up ones personality provides a way of assimilating feelings and memories which might otherwise be difficult to accommodate. Perhaps the fragmentation of the person creates a unique way of processing the horrific experiences of early childhood. It is conceivable that this sort of developmental response could be advantageous, especially if it promotes the individual's ability to carry on with the demands of everyday life.

In their comprehensive analysis of Wakefield's definition, Lilienfeld and Marino (1995) also make this point. Drawing an analogy with purely physical conditions they give the examples of influenza and gastro-enteritis. The primary symptoms of the former - coughing and sneezing, and high temperature - are adaptive responses to infection. Similarly the vomiting which occurs in response to food poisoning indicates that the digestive system is operating as it has evolved to, in expelling the toxic substance. Lilienfeld and Marino argue that, similarly, the symptoms of some mental disorders may be understood as adaptive responses to aversive phenomena. They note, citing

Seligman (1971) and McNally (1987), that simple phobias of stimuli such as 'snakes, heights, water, and darkness' are likely to be excesses of fears for which humans have been 'evolutionarily prepared'. Lilienfeld and Marino propose that a more accurate description of what is occurring is that mechanisms are carrying out their adaptive functions in inappropriate contexts, rather than failing to carry out that function.

Relatedly, they propose that some phobias could be seen as adaptive relative to the environment in which they would have evolved. For example, stimuli such as blood and injury would have represented significant danger to primitive peoples. They claim that phobias of this kind are associated with changes in the autonomic nervous system, such as reduced pulse and blood pressure, which have the effect of minimising the loss of blood. Lilienfeld and Marino suggest that in modern society wherein there are effective methods for dealing with injury, a fear of blood is less appropriate. An example of a similar phenomenon in the animal kingdom is provided by Dawkins (1982). Many of us have observed the obviously dangerous practice of moths flying into the flames of candles. Dawkins suggests that before the widespread use of candles, small points of light in the darkness would typically have been small openings in caves or other enclosures, or distal celestial objects. Interestingly the latter are often used by insects as compasses hence moths will often circle the light source in an attempt to keep the light at a fixed orientation. With a distal object this fixed orientation would enable them to travel in a straight line. So, in stark contrast to Wakefield Lilienfeld and Marino propose that "...some phobias may actually be the product of fear systems performing too similarly to the way they were designed" (p. 416). This raises the question of how useful an evolutionary approach is in distinguishing normal from abnormal functioning. As the context of human existence has changed, touchstones of adaptiveness may have also changed, blurring the distinction between adaptive and non-adaptive function.

Further complicating the application of an evolutionary understanding are exaptations, which are adaptively neutral mechanisms. While all features of an organism are products of the process of natural selection, exaptations differ from adaptations in that they function in ways which differ from those for which they were originally 'designed'. According to Lilienfeld and Marino some examples of these are "religion, political beliefs, arithmetic ability, music, art, literature, and specific athletic and motor

skills” (p. 412). They suggest that these capacities have not been selected for, but have rather developed out of the presence of general mechanisms which have been designed for other purposes. Considering the general plasticity of the brain such exaptations are not surprising. Dennett (1991) speaks of ‘a complex brain of unrivalled plasticity’ (p. 190). And he goes on to say that, “Our brains are equipped at birth with few if any powers that were lacking in the brains of our ancestors 10 000 years ago” (p. 190). He claims, therefore, that the remarkable advancements of human kind over the last decamillennium must be due almost entirely to the novel application of old systems. Explicating this notion, Dennett introduces a computer analogy wherein these novel uses are likened to software which may be run on the same old hardware.

According to Dennett, language is a good example of this process. He states that the brain of the first *Homo sapiens* was in terms of both size and shape almost identical to that of human beings alive today. And yet he proposes that language probably emerged within the last 150 000 years, subsequent then to the development of the brain of modern hominids. Dennett suggests therefore that the emergence of language did not correspond with changes in neuroanatomy but rather made use of systems which were already in place. He writes, citing Calvin (1989a): “The innate specialisation’s for language, hypothesised by the linguist Noam Chomsky and others, and now beginning to be confirmed in details of neuroanatomy, are a *very* recent and rushed add-on, no doubt an exploitation of earlier sequencing circuitry” (p. 190). Dennett adds that the most impressive development of human psychological processes, as evidenced by the emergence of ‘civilisation’ including activities such as agriculture and cooking, occurred even more recently, within the last ten thousand years.

The central point here is that the context of modern life may require the novel functioning and novel application of mental mechanisms; functioning which differs from that for which the mechanisms were ‘designed’ through the process of natural selection. As Dennett argues, monumental changes have taken place during the last ten thousand years in the way that human beings live and these changes may be correlated with changes in psychological functioning. Hunter-gatherer societies would have had different intellectual demands. So if the so-called normal operation of mental mechanisms diverges from what Wakefield would refer to as its natural function then

Wakefield's analysis of dysfunction is problematic because it then has no marker for normal function. And more generally, considering the enormous changes in human societies it is reasonable to question the relevance of delineating the optimal functioning of psychological processes of modern *Homo sapiens* according to ancient touchstones of normality. As demonstrated by the seemingly dare-devilish behaviour of moths, what is adaptive in one context may not be in another.

Another difficulty with Wakefield's analysis of dysfunction, identified by Lilienfeld and Marino, is that the evolutionary approach demands a sharp distinction between normal and abnormal function, however some researchers argue that a number of mental disorders are best understood as extremes of ubiquitous psychological dimensions. In this case normal and abnormal are conceived of as lying at opposite ends of a continuum wherein each merges in gradually with the other somewhere in the middle of the spectrum. This conceptualisation has been applied, in particular, to personality disorders and some mood and anxiety disorders. This poses difficulty for Wakefield's theory because one would expect a precise and qualitative difference between the correct operation and disoperation of a mechanism according to the yardstick of adaptive function. While Wakefield has responded to this problem by suggesting that deviation from adaptively normal function may be gradual, as Lilienfeld and Marino note, this seriously undermines his theory. The central purpose of the theory being to establish a precise way of ascertaining abnormal function. If evolution provides no clear marker for deviance then there must be other more significant factors involved in the explication of mental disorder.

Another problem for Wakefield's definition of mental disorder is the analysis of harm which he utilises. As mentioned earlier, this is said to be intimately connected with social values and expectations. Something which is harmful is only harmful in so far as it contradicts these values. The key difficulty with this approach is that it assumes too much commonality between people and diminishes the significance of purely subjective variables. There is more to harm than the social dimension. Harm is first and foremost, something which is experienced. The social evaluation of harm must include an evaluation of the experience. And the experience is not just a social one. With regard to psychological diagnosis, the evaluation of harm will be heavily influenced by social

forces but these may still be distinguished from individual or subjective factors. The point here is that Wakefield fails to acknowledge in his definition the personal component of mental disorder. The DSM includes this with the notion of distress, but for Wakefield distress is a socially determined phenomenon as opposed to a personally experienced one.

And while Wakefield addresses the social as well as the biological dimensions of mental disorder, Wakefield's analysis relies on a link between evolutionally determined biology, and society, both of which must correlate according to his definition. However, societies are not always controlled by evolutionary design, and do not always value behaviours which enhance survival. It has, for many years, been fashionable in a number of Western societies, to bathe oneself in the sun. For whatever reason, being tanned has been highly valued. So much so, that people sometimes expose themselves to the sun until their skin becomes burnt, in order to darken their skin colour. In the long term this behaviour can have serious effects on health. Thinness is also valued and attaining the extreme thinness which is considered to be desirable can cause physical harm. These behaviours are valued yet their value is not clearly tied to evolutionally directed goals, in other words they have no 'natural' benefits. In his book, "The Sane Society", Erich Fromm (1956) states:

The fact that millions of people share the same vices does not make these vices virtues, the fact that they share so many errors does not make the errors to be truths, and the fact that millions of people share the same forms of mental pathology does not make these people sane (p. 15).

There is a tendency to equate commonality with sanity. As if to say that commonality of value is evidence of the acceptability of that value. Similarly Wakefield asserts that the normal and natural operation of mental mechanisms will correlate with common social value, but there is no reason why it must. The lives of human beings have changed markedly. Hence it can be assumed that the mental mechanisms which would have been utilised by our ancestors several millennia ago are the same ones which human beings are using today. Evolutionary change is slow; much slower than social change, and hence it could not possibly match the whimsical changes in value which occur in social groups. Arguably human nature is constrained to some extent by evolution, however

unlike other animals we can use our innate abilities in novel ways, hence manipulating the basic predetermined capacities with which we were endowed, in search of rewards which may have little or nothing to do with procreation.

The point which is obviously related to one made earlier, is that there is no reason to believe that biology and society converge in the manifestation and understanding of mental disorder. According to Wakefield psychopathology involves disruptions of both biological and social order thereby assuming that there will be commonality. However based on the argument outlined earlier, detailing the relative stasis of the hominid brain throughout a period in which there were many important social changes, there may be no such commonality. It is possible, then, that a behaviour which is disvalued or considered to be deviant will not necessarily have a corresponding biological basis.<sup>4</sup>

Supportive of this view is the appearance and subsequent disappearance of some disorders in various diagnostic manuals. Obviously the condition termed 'drapetomania' had no biological basis and was strongly socio-politically embedded. More recently homosexuality was removed from diagnostic manuals and in the most recent edition of the DSM, passive/aggressive personality disorder was removed. Oddly though Wakefield uses these examples to support his argument. He suggests, though not explicitly, that in retrospect drapetomania was not a mental disorder, but rather a convenient label for a behaviour which was at that time disvalued. Obviously nobody wanted their slaves to escape. Homosexuality is treated similarly – as not a genuine mental disorder. Homosexuality does not appear to be characterised by dysfunction, therefore its inclusion in previous diagnostic manuals would seem to be due entirely to socio-political factors. Wakefield's interpretation of such examples discounts the very important fact that at one time these conditions *were* valid diagnostic categories. This clearly demonstrates the opposite argument – that mental disorders do not depend primarily on biological indicators, but rather may be strongly influenced by societal norms.

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<sup>4</sup> The biological basis referred to here is not necessarily manifest in physiology. Wakefield (1997) explains that mental dysfunction is not dependent on, or rooted in, brain dysfunction. Rather mental disorder involves the disruption of psychological mechanisms which may or may not be associated with malfunction in the brain. The term biological above is used only to describe the evolutionary aspect of

Wakefield attempts to distinguish these 'bogus' disorders from genuine ones by claiming that 'real' disorders are out there in the world regardless of the explication and understanding of them. So drapetomania was never a mental disorder because it had no dysfunction component. A genuine disorder, on the other hand, is believed to have a natural instantiation. Lilienfeld and Moreno argue that this is Wakefield's central error. They state that his conceptualisation of disorder, "...may actually prolong scientific debate on a fundamentally non-scientific issue" (p. 418). They suggest that disputes concerning which conditions require intervention should be settled according to the application of social values and social need, rather than on the basis of poorly defined criteria of dubious scientific standing.

## SUMMARY

As demonstrated, there are a number of problems with contemporary definitions of mental disorder. The definition provided in the DSM-IV has two main weaknesses. Firstly it fails to provide sufficient detail of the concept of dysfunction - it states only that the dysfunction may be behavioural, psychological or biological. And secondly in describing the cultural dimension of disorder it utilises the concept of expectability which is determined according to statistical norms. Essentially what is meant by the term dysfunction (in the DSM definition) is the breakdown of physiological systems. This captures the biological dimension of mental disorder. But there is no explanation of what normal function is and how normal and abnormal function can be understood. In terms of the social aspect, normality is determined by statistical frequency, but as argued, this is problematic because something which is unusual is not always harmful.

Wakefield circumnavigates this problem by focusing on the concept of 'harm'. According to Wakefield, the social dimension of disorder is manifested in the ascription of social value, which determines when and if something is harmful. So in line with the beliefs and customs of particular cultures, certain behaviours will be considered harmful. But this need not rest on a statistical analysis of expectability. What is believed

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Wakefield's definition. For more detail on the role of evolution in the understanding of psychological mechanisms refer to Buss (1995) who presents a comprehensive analysis of it.



to be harmful will probably also be epidemiologically rare, but this is not an essential criterion. In response to the other weakness of the DSM definition, Wakefield construes the notion of dysfunction as the failure of 'internal mechanisms' to operate according to their evolutionary 'design'. In this way he ties dysfunction firmly to biology and he uses the idea of adaptive function to determine normality. But as argued, Wakefield's definition also has some drawbacks. His analysis of dysfunction, while more detailed than the DSM's, runs into difficulties at the point at which it evokes evolution as a way of demarcating normal function. On investigation, evolution has little explanatory depth and seems to result in more questions than answers, in response to the various issues.

Also, Wakefield's definition fails to acknowledge individual variables. This, in contrast, is one of the strengths of the DSM definition. With the concept of distress, the DSM definition permits a personal, subjective dimension which is overtly absent in Wakefield's analysis. According to Wakefield mental disorder is a 'harmful dysfunction' wherein harm is necessarily dependant on social consensus. But harm is not only a social phenomenon. The experience of harm, while mediated by social forces, retains an important core of that which is quintessentially personal. It is important to allow for individual variables in the definition of psychopathology. Above all, mental illness is something that is experienced and whether it is essentially biological or social, it manifests in people and different people will experience it differently.

Another problem with Wakefield's definition of mental disorder is its inflexibility with regard to its two key components. According to Wakefield, a disorder has two necessary and sufficient conditions – harm and dysfunction. Both of these must be present for a condition to be classed as a disorder. As argued this is problematic because it entails that these two aspects will converge however this remains an unsubstantiated assumption. This analysis does not allow for the possibility that some disorders may not have a biological origin and a corresponding dysfunctional mental mechanism. Wakefield clearly supports a bio-medical model of psychopathology even though he appears to give equal status to the concept of harm.

According to both Wakefield and the DSM, mental disorder is rooted in mechanistic dysfunction, in other words it has a natural instantiation. It involves a breakdown of mental processes in the same way that medical disorders involve the breakdown of physiological processes. As discussed earlier this approach has been characterised as following the medical (or bio-medical) model of psychopathology which views mental disorders as discrete diagnostic entities. The following chapter examines how this conception of mental disorder has influenced, and is evidenced in, the DSM classification.

## CHAPTER 2

# THE CLASSIFICATION OF MENTAL DISORDER

Like all sciences, psychology relies on classification to systematise knowledge and enable explanation and understanding of the field. Old Hindu Scriptures suggest that as long ago as 1000 BC, attempts were made to classify mental disorders (Scharfetter & Stassen, 1995). Classification is fundamental, not only to scientific endeavours, but also to the undertakings and understandings which lay people execute during everyday, mundane activities. And Sokal (1974) suggests that even before the evolution of *Homo sapiens*, an ability to classify would have been of general adaptive significance across many animal species. Without classification our thoughts and memories would be a hotchpotch of complex and perhaps meaningless data. Classification provides a way of organising information, so that we can learn, and communicate about, the world around us. Millon (1991) describes classification (in the field of psychopathology) as “...a procedure for constructing groups or categories and for assigning entities (disorders or persons) to these categories on the basis for their shared attributes or relations (p. 246).

Systems of knowledge use classification to divide objects and phenomena into particular groups according to certain principles or theories, so as to allow explanation and understanding of them. For example, in order to explain a meteorological phenomenon it would be necessary to divide up the different sorts of matter, and for ease of communication, to ascribe labels to them. Things which might be important would be clouds, air pressure, and precipitation. The weather system would be described according to these sorts of concepts, so different types of matter and events would be put into the appropriate categories and the weather would be explained in terms of these particular labels and the interaction between them. As expressed by Millon, the grouping principle is commonality; objects or events are categorised according to

similarity so a category will consist of objects or events which share common “attributes or relations”.

Although similarity plays a key role in categorisation, this role is guided by the overall goal of the classification process. This point is succinctly expressed by Medin (1989). He states: “Categorisation involves treating two or more entities as in some way equivalent in the service of accessing knowledge and making predictions” (p. 1469). The equivalence which is noted is not arbitrary; rather it is construed in terms of certain preconceived goals, although these goals might be altered according to information which is yielded by the classification procedure and the utilisation of this procedure. Categories and their boundaries, will be created according to knowledge which is already available and the type of knowledge and predictive power which is desired. To put it simply, the apprehension of similarity occurs within a theoretical framework, one that adheres to basic scientific principles (or at least aspires to).

Like the natural sciences, although classification in psychopathology is to some extent a theoretical exercise, it should be noted that its goals are predominantly pragmatic, as explained by Bassett and Beiser (1991). They state: “The primary goal of a diagnostic classification system in a clinical setting is to communicate information useful in making treatment and management decisions about patients” (p. 273 ). Poland, Eckardt & Spalding (1996) suggest that there are two main purposes for psychiatric nosologies: to improve the efficacy of clinical activity and to optimise scientific research programmes which are concerned with the understanding and treatment of mental disorder. According to Edlund (1986) there are three main uses of psychiatric classifications: to elucidate causal mechanisms, to predict the course of illness, and to determine public health requirements. Perhaps the ultimate objective of classification in this field, is the successful treatment of people who have mental disorders. Hence the supreme test of the categorical system’s efficacy will be a measure of this success. Although this chapter will be largely concerned with theoretical issues, it is important not to lose sight of the ‘human’ objectives.

The impetus of classification is usefully, although simplistically, illustrated by the example of meteorological phenomena. Imagine a weather forecast which does not

utilise classification. Such an image is difficult to generate. Different cloud names, such as cirrostratus and cumulonimbus are necessary because different cloud types have different environmental effects. Without classification, it would be difficult to explain the relationships between phenomena and moreover it may be impossible to communicate anything at all, about the event considering that language itself relies on categorisation. The utility of this type of classification, which is common in the general sciences, where empirical phenomena provide the basis of the categorical system, is obvious. Unfortunately information within the social sciences is by its very nature, more difficult to classify. This is particularly true of psychiatry and psychology where the goal is to explain human behaviour with reference to subjective states and internal mechanisms which are not readily amenable to empirical study. As described by Millon, diagnosis involves the identification of 'clinical attributes', the ascertainment of which is rather more complex than say, the identification of a cloud or a bolt of lightning. The difficulty of acquiring empirical information of this kind is only one problem for psychiatric classification. Others include establishing thresholds of clinical significance and delineating one disorder from another, although both of these problems are in part due to empirical issues.

Historically classification in clinical psychology and in medicine has been notably under-researched (Parshall & Priest, 1993) and probably under-discussed. However in recent years topics in this area have received more attention (Spitzer, 1991; Stein, 1993). Taxonomy in psychopathology, remains though, a complex and challenging field, distinguished by a number of unresolved conundrums. The goal of this chapter is to elucidate the workings of classification and to outline and discuss some of the primary issues.

## *THEORETICAL FOUNDATIONS*

As explained above and explicitly stated by Barlow (1991): "Classification is at the heart of any science". Understanding the way that it operates is therefore vital to the comprehension and advancement of knowledge. It may seem on the face of it, that the process of classification is straightforward. All that is required is an analysis of the

characteristics of say, objects, and the allotment of these objects to particular categories, based on the nature of the characteristics. Needless to say, there is more to it - as already noted this type of process is difficult when the subject-matter is human mental disorders. To understand why this subject-matter is problematic it is helpful to look at the theoretical underpinnings of classification.

This theoretical basis is not immediately obvious. Classification has become so commonplace that its philosophical roots are often forgotten. There has however been a revival of interest in the subject in recent years, yielding several enlightening analyses. One such analysis by Schwartz and Wiggins (1986) discusses the influence of logical empiricism on psychiatric classification. The focus of the paper is on the ideas of Carl Hempel, who at the invitation of prominent psychiatrists of the day, wrote extensively on the theoretical foundations of systems of classification in the context of psychopathology. According to Schwartz and Wiggins, Hempel's logical empiricism has had an enormous influence on recent editions of the DSM. As a particular philosophy of science and a guiding metatheory, logical empiricism has been widely endorsed as the best approach for the taxonomy of mental disorders (Kendell, 1975 & 1983), and Hempel is one of the theory's more recent and most rigorous advocates.

Hempel claims that scientific terms have two primary functions. Firstly, to provide descriptions of observable data and secondly, to carry out functions within the context of "general laws and theories" (Hempel 1965, pp 139-140). He relates this view to the classification of psychopathology, claiming that like other sciences, this field also utilises these two conceptual functions. Within the field of psychopathology, descriptive or observational data is symptomatology. Diagnostic categories generally consist of symptom lists which specify particular cognitive, emotional or behavioural conditions. The laws and theories which Hempel refers to are involved in the postulation of etiologies and etiological mechanisms. Hempel claims that an analysis of etiology must be interpreted as a quest for theories which will predict and explain disorders. While this process should be tied to descriptive data, it is fundamentally theoretical, involving the formulation of theories which can explain empirical phenomena.

So logical empiricism claims that scientific terms should not only be closely linked to empirical phenomena but should also fit into a theoretical framework. The process by which this is achieved is referred to, by Hempel as explication (Hempel, 1970). As stated by Schwartz and Wiggins (1986): “An explication of a term combines a meaning analysis with an empirical analysis of it” (p 105). A meaning analysis consists of what the term ‘means’ to the people who use it, and includes the different ways and contexts in which it is used. An empirical analysis, on the other hand, is concerned with the description of characteristics which anything must have in order to be allocated a particular label. These factors can be viewed as different sorts of verification. The meaning analysis measures the extent to which a particular term is successful in conveying particular information. It determines whether or not a concept embodies the meaning for which it was intended. The empirical analysis measures the connection or correlation between the concept and its corresponding worldly manifestations. This analysis looks at the empirical data which the concept is supposed to represent.

Notions of both observable and theoretical data are considered to be equally important. This theme is further elaborated with Hempel’s concepts of “empirical import” and “systematic import” which he says ensure that terms are entirely scientific (Hempel, 1965). The former refers to the match between terms and their empirical correlates and should ensure that diagnostic criteria refer to specific symptoms. The latter refers to the place that particular terms have within a theoretical network and should ensure that diagnostic criteria are embodied within general laws and theories. Hempel believes that empirical import is best achieved through the use of operational definitions although he states that within the field of psychiatry (which is not conducive to the delineation of exact boundaries and readily observable mechanisms) these definitions will exhibit less precision than in the general sciences.

Systematic import, on the other hand, is established by ensuring that concepts perform functions within general laws and theories. For instance a concept which has a narrow focus should be interconnected with the broader theoretical picture of similar or related phenomena. For example the way that different symptoms are clustered together to form particular disorders exhibits systematic import. This is done according to laws and theories about symptoms and the relationship between symptoms. It is useful at this

point to postulate a circular model in order to understand Hempel's conception of this relationship. The theoretical system creates a framework within which new theories and new observations are understood. The observations in turn shape the theoretical framework, giving rise to a dynamic process wherein the advancement of knowledge involves repeated modifications to the status quo. With regard to this dynamic process McHugh and Slavney (1983) state that, "...concepts and operations live in reciprocal relationship, and progress comes as each enhances and modifies the other" (p. 8).

As already mentioned, Schwartz and Wiggins (1986) claim that Hempel's logical empiricism has been influential in recent editions of the DSM. The development of the DSM-III represented a significant shift towards a more empirically based classification system. Previous editions relied more heavily on theory, especially psychoanalytic theory. The recent emphasis on descriptive information in the form of more accurate symptom lists, allows extensive use of the DSM by clinicians who have a diverse array of theoretical beliefs. Its practical use can be divorced from the issues related to theoretical explanations of mental disorder, which are many and varied. In fact, the DSM-III and III-R make their position on this matter explicit by stating that they are atheoretical. The DSM-IV on the other hand avoids any reference to theory. However, clearly this position is problematic. According to a logical empiricist approach, which developers of the third DSM were apparently following, theory must play an important role in the formation of taxonomies. The way that various symptoms are grouped together should be representative of prevailing theories about syndromes and the particular mental and physiological mechanisms which these syndromes are thought to involve.

It seems that those involved in the development of the DSM-III were so focused on the need for a more strongly empirically based manual that they overlooked the significance of theory and in so doing, failed to uphold their logical empiricist ideals. Follette and Houts (1996) write: "...while adopting the accoutrements of logical empiricism such as "operational definition" and "scientific progress" the modern DSMs have also abandoned the substance of that philosophy of science" (p. 1126). The failure to explicate theory in recent editions of the DSM amounts to a serious shortfall in scientific rigour. Theory is central to all forms of scientific endeavour. Hypotheses can



not be adequately tested if they have not been adequately expressed. And if they can not be tested then they can not be falsified; falsifiability being an important and perhaps essential component of progress in science (Lakatos, 1974; Popper, 1969).<sup>5</sup>

It is a mistake to assume that a classification system is atheoretical simply because it touts a foundation of empirical fact (Blashfield & Livesly, 1991; Millon, 1991). Arguably no classification system can be entirely atheoretical. Discussing the development of the DSM-IV Spitzer predicts that "...when final decisions are made about the DSM-IV, they will still be based primarily on expert consensus, rather than on data, as was the case with the DSM-III and DSM-III-R" (p. 294). Having had a leading role in the development of the DSM-III and its revised edition, Spitzer is one of few theorists in this field with intimate knowledge of his subject matter. Elaborating on the above comment he claims that most of the proposed modifications to the manual are based on 'conceptual concerns' rather than on new empirical data. He provides some examples such as the proposal to exclude from the manual, the category of organic mental disorders, the proposal to give greater weight to negative symptoms in the delineation of schizophrenia and the proposal to incorporate pain disorders in the manual in the form of a major diagnostic class. Interestingly the DSM-III-R, in describing the decision-making which was involved in producing the manual openly states:

"Most advisory committee decisions were the result of consensus that emerged among committee members. However, several controversies, particularly in the areas of childhood, psychotic, anxiety and sleep disorders, could be resolved only by actually polling committee members" (APA, 1987, p. xx).

Clearly, the investigative process which culminated in the DSM-IV was dependant on both theoretical and empirical issues and that is exactly as Hempel would have it. Hempel admits that the application of logical empiricism within psychiatry gives rise to some unique difficulties. For example, in relation to the use of operational definitions he states that the concept of 'operation' should be interpreted in a liberal sense (Hempel, 1965); probably because many diagnostic criteria are not readily observable, but are rather as Poland et. al (1995) point out "...highly inferential in character (e.g.

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<sup>5</sup>Falsifiability will be discussed more extensively in chapter 10.

hallucinations, delusions, loss of interest, depressed mood)” (p. 240). Hempel claims nonetheless that strict operational criteria for all diagnostic categories should be the aim of psychiatric nosology.

Whether this goal is attainable is debatable, however it seems that this is one view which has influenced contemporary approaches to the classification of psychopathology. But what *other* philosophies have contributed to recent DSMs? Broadly speaking, these manuals adhere to a positivist position wherein knowledge is seen to depend on the facts of the world and accordingly the ultimate test of truth is the fit between theory and data (Stein, 1991). This philosophy has its roots in the writings of Comte, Mill, Berkeley, and Hume all of whom can be described as empiricists.<sup>6</sup> Positivism and empiricism are consistent with the bio-medical, disease model of mental disorder outlined in the previous chapter. As explained therein, mental disorders are seen as discrete entities which are materially instantiated in the form of psychophysiological dysfunction. This conception of mental disorder is evidenced in the DSM’s categorical approach wherein syndromes are presented as distinct entities with their own unique pattern of objective signs<sup>7</sup> (Nelson-Gray, 1991; Salzinger, 1986).

Positivism is just one way of describing the DSM’s medical-oriented approach to the understanding of psychopathology. Follette, Houts & Hayes (1992) describe this approach as following the ‘discovery narrative’ of science. This narrative, they claim, is one way of explaining historical and social events. Essentially, different narratives are simply different ways of understanding and interpreting science. The discovery narrative sees science as the uncovering of objective truth which can be achieved through the application of specific rules and procedures. Follette et al. contrast this with the invention narrative which views science as a ‘constructive’ activity dependent not only on matters of ‘fact’ but also on social judgement and social need. According to the authors, it is the discovery narrative which has shaped and continues to shape the field of psychopathology. They claim: “Mental health professionals are steeped in the discovery narrative” (p. 326). Their point is that this particular understanding of the

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<sup>6</sup> The positivist tradition is typically contrasted with the hermeneutic tradition which sees knowledge as necessarily dependent on subjective understanding (Stein, 1991). In this respect and many others positivism is indistinguishable from empiricism (A dictionary of philosophy, 1979).

<sup>7</sup> The DSM’s categorical approach will be discussed in more detail later.

study and application of clinical psychology and psychiatry has become so profoundly entrenched that it is rarely challenged or even noticed.

According to Follette et al. (1992), the discovery narrative was formally accepted in the field of psychopathology with the inception of the DSM-III - the first diagnostic manual to adopt the methodology of medical science. Like purely physical conditions, mental disorders were theorised to have biological underpinnings whether or not these had yet been 'discovered'. And thereafter this approach became the accepted one perhaps with the promise, Follette et al. suggest, "...That...medical science will yield the same remarkable results for behaviour problems that it has with heart disease and tuberculosis" (p. 325). Obviously this remains to be seen.

### *HOW DOES CLASSIFICATION WORK?*

As mentioned earlier classification is based on relations of similarity, and similarity is perceived or perhaps construed according to a specific set of characteristics and the proposed association between them. It is not simply a matter of noting observable data. Rather, the procedure involves the application of theories of ontology and the influence of practical objectives. To ensure that concepts function correctly Hempel claims that their empirical and systematic import must be regularly evaluated; that is, one must check that they have a clear empirical basis and that they convey the intended meaning. Concepts should refer to the objects or phenomena which comprise their categories. In his comprehensive analysis of concepts and categories, Medin (1989) makes the following important points:

Roughly, a concept is an idea that includes all that is characteristically associated with it. A category is a partitioning or class to which some assertion or set of assertions might apply. It is tempting to think of categories as existing in the world and of concepts as corresponding to mental representations of them, but this analysis is misleading...The world could be partitioned in a limitless variety of ways, yet people find only a minuscule subset of possible classifications to be meaningful. Part of the answer to the categorisation question likely does depend on the nature of the world, but part also surely depends on the nature of the organism and its goals. Dolphins have no use for psychodiagnostic categories (p.1469.).

Medin's comment is crucial. We should at all times note, that although concepts and categories are often based on empirical facts, they are also powerfully related to human nature and human objectives. We use categories of mental disorders to understand and treat particular conditions. The delineation of categories is as much dependant on these factors as it is on simple empirical data. Moreover the interpretation of empirical data is itself influenced by such factors. The way that phenomena are perceived and interpreted is dependant on the conceptual systems which are already employed. For instance when a test of neurophysiological functioning is carried out, results are interpreted according to the way that the brain is currently understood. Different areas of the brain are believed have different functions and particular neuro-chemicals are thought to be involved in particular types of cognitive activity. For example the hippocampus is often implicated in memory dysfunction and therefore studies of memory function often focus on changes to this brain structure. The interpretation of raw empirical data will inevitably be significantly affected by this prevailing understanding of brain structure and functioning.

In his discussion of conceptual structure, Medin takes a close look at similarity, showing that it is more complex than one might intuitively believe. It is guided by often elusive principles and theories which reveal a profound and intriguing conceptual framework. In an examination of this framework, Medin claims that there has recently been a shift from the classical view to the probabilistic view of concepts. The classical view claims that members of a category share some basic characteristics and that a mental representation of a category consists of a list of characteristics which are necessary and sufficient for membership. Medin identifies a number of problems for this view, two of which are stated below:

1. Some examples of concepts are believed to be more typical than others, e.g. A robin is a more typical example of a bird than a penguin.
2. It is often impossible to list defining features and when achieved this can preclude prospective members: it is extremely difficult to determine necessary and sufficient conditions.

The classical view can not account for typicality effects, such as that expressed by the first point; its approach, it seems, incorporates a rigidity which is not representative of

common conceptual practice. Concepts do not always have precise boundaries; they are often only loosely defined (Smith, Rips and Medin, 1984). The possibility, therefore, that extensive lists can be devised which include all features is remote. Characteristics can vary greatly across members; a robin and a penguin are both types of bird but a robin is believed to be more representative of that class. This type of discriminatory effect can not be explained by the classical approach.

The downfall of the classical view is related to the rise in popularity of the probabilistic view. This view states that category membership utilises the notion of typification, a notion which poses difficulty for the classical account.<sup>8</sup> According to this theory, categories are organised around prototypes or exemplars which typify the category, by incorporating all the most essential characteristics. Categories and their boundaries are in this case only loosely defined, and members may have all or only few of these important characteristics. Hence a penguin may be described as a less typical or exemplary type of bird, than a robin. The approach to categorisation, of the DSM-IV - and its recent predecessors - is an example of the probabilistic view (Medin, 1989; Frances et al, 1991; Carson, 1991). Many disorders consist of symptom lists which may be manifested in a number of different ways. For example, depression may be diagnosed if dysphoric mood occurs with any five of the other nine possible symptoms. So two people with the same diagnosis may have quite different symptom patterns, and one person who is depressed may be described as a more typical case than another with the same diagnosis.

Typicality, like similarity is related to theories and objectives as expressed in the following excerpt from Schwartz and Wiggins (1987):

Typifications, in general terms, are situation tied or project determined... Typifications are one sided. One set of typifications will give access to only certain features of things and people. A Different set of typifications will have to be applied in order to gain access to other features of the same things and persons (p.72).

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<sup>8</sup> A detailed account of typification is given in an article of the same name by Schwartz and Wiggins, 1987.

Something is deemed typical in relation to a particular aim or theoretical view. Killing a human being in the context of war is not classed as a criminal act, however killing during times and places of peace will bring a charge of murder and severe punishment. The context of objects, behaviour and events is important to typification and the categorisation process. As explained by Medin a category consisting of "...children, money, photo albums and pets," may seem strange, until it is revealed that the category consists of things which should be removed from a house when there is a fire risk. Notice that generally these things have little in common, yet they can all fit into one category. It is this type of example which is problematic for the view that similarity alone is the driving force of conceptual organisation.

Medin presents the view that similarity should include "attributes, relations and higher-order relations." So, similarity is not simply a matter of noting observable or other equally tangible features. Rather it involves perceiving and interpreting properties according to conceptual organisation and structural systems. For instance, Medin and Shoben's (1988) investigation of this process, found that grey hair and white hair were believed to be more similar than grey hair and black hair but that grey clouds and white clouds were believed to be less similar than grey clouds and black clouds. One interpretation of this is that grey and white hair are interrelated by the theory of ageing while grey clouds and black clouds, may both be a sign of bad weather. This simple example captures the thrust of the present exposition; that the postulation of similarity is guided by theory, and hence so too is categorisation.

## *THE DSM CLASSIFICATION*

As mentioned above the DSM takes a probabilistic categorical approach to the classification of mental disorder.<sup>9</sup> Poland et al. (1996) refer to the DSM classification as a "...mixed monothetic/polythetic, lenient, categorical approach" (p. 240). In a monothetic taxonomy, each category is associated with a distinct group of criteria which are individually necessary and together sufficient for category membership. In contrast a polythetic taxonomy allows for the differential grouping of criteria. In this case no

individual criterion is considered necessary and several different combinations of criteria are sufficient for category inclusion. The DSM uses both monothetic and polythetic criteria in its delineation of mental disorders, meaning that there is a combination of both essential and nonessential conditions in its various categories. For example, as explained above, a diagnosis of depression requires the presence of dysphoric mood or loss of interest and pleasure, however either of these primary symptoms may be coupled with any five of the other listed criteria.

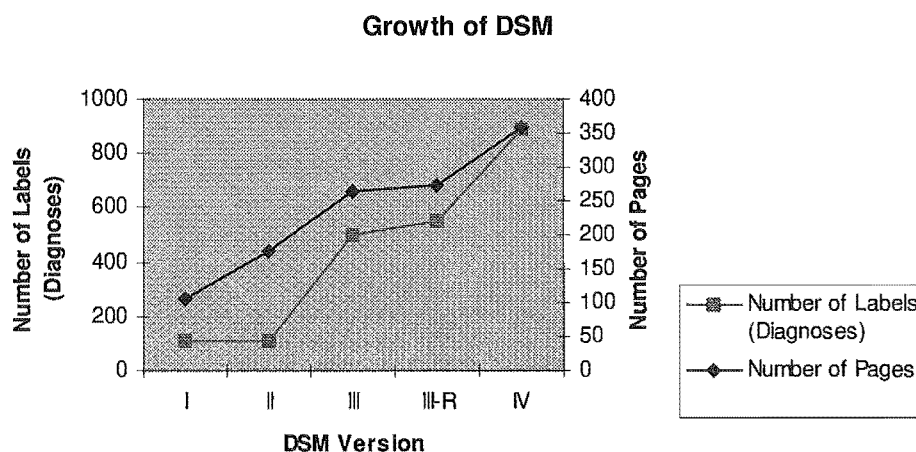
The categorical approach to classification requires little explanation. Most importantly it is non-quantitative and absolutist; that is categories are seen as discrete entities with particular criteria sets which determine in an all-or-nothing sort of way, whether category membership is met. Rosch and Lloyd (1978) describe this as the “in or out” model - as compared to the prototypical model - of categorisation. Importantly, the categorical approach embodies the bio-medical model of mental disorder, wherein signs and symptoms of particular disorders are thought to indicate the presence of a disease entity (Clementz & Lacono, 1993). Proponents of this approach assume that the various disorders are qualitatively different from each other and also that they are qualitatively different from normal functioning.

Poland et al. (1996) describe the DSM’s approach as a ‘lenient’ categorical one, as there is some overlap between some of its diagnostic categories and there are some ‘mixed’ and ‘residual’ categories. An example of a mixed category is schizoaffective disorder, which allows for the combination of the primary symptoms of schizophrenia and depression. A residual category refers to conditions which have some of the features of a disorder but not enough to warrant the formal diagnosis of that syndrome. For instance, depressive disorder not otherwise specified and psychotic disorder not otherwise specified. Another example of the DSM’s flexibility is the fact that there are in some cases numerous ways to meet the criteria for diagnosis. For example there are apparently 93 different ways of meeting the criteria for a diagnosis of borderline personality disorder (Frances, Pincus, Widiger, Davis, & First, 1990).

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<sup>9</sup> I will be referring throughout, indiscriminately, to the ‘DSM’ as most of the researchers in this area discuss the general approach of recent manuals without reference to any one in particular.

Also central to the DSM classification is the multi-axial organisation of the manual, which groups disorders into a number of general kinds and encourages clinicians to simultaneously consider alternative dimensions of pathology when formulating a diagnosis. This means that an individual may be given multiple, yet not contradictory diagnoses. This approach allows for the consideration of a wide range of factors in the process of clinical assessment. While this and other changes, represent advances in recent decades, in the DSM's approach to the taxonomy of mental disorder, a number of researchers claim that it falls short of what is required (e.g. Carson, 1991; Poland et al., 1996). One of the main criticisms refers to the continued use of an essentially categorical approach. Carson writes: "...what evidence do we have that the objectively seamless bleedings of disordered behaviour actually presented to clinicians are manifestations of the finite and discontinuous set of underlying dysfunctional entities envisaged by a taxonomic system of the classical categorical variety?" (p. 302).



*Figure 1.* The growth of successive editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Versions I, II, III, III-R, and IV are the first, second, third, revised third, and fourth editions, respectively.<sup>10</sup>

Similarly Follette et al. (1992) note the proliferation of diagnostic categories in the DSMs and question the supposition that this represents the discovery of more and more disorders. Figure 1 shows the expansion from each manual to the next in the number of pages, and the number of diagnostic labels. Follette and colleagues suggest that 'discovery' in science should lead to simplification in classification, and hence a

<sup>10</sup> This graph is copied from the article by Follette and Houts (1996).



reduction in the number of categories rather than a proliferation of new labels. Comparing psychiatry to another science, they note Hempel's observation that as biology has progressed, with the incorporation of evolutionary theory, there has been a reduction in the number of categories. With the appearance of evolutionary theory classification was no longer dependant on external features but on phylogenetic and genetic characteristics. Within psychiatry such internal structures and internal mechanisms are typically unknown.

The categorical system is organised according to the view that there are clear boundaries between disorders but generally this is not the way that things occur in nature (Frances et al, 1991; Thakker, in press). As pointed out by Carson, this is especially apparent in the domain of psychopathology. This problem is acknowledged in the DSM-IV with the proposal that although disorders are presented as apparently distinct entities, this may not be the case. Clinicians are requested to exercise discretion in this regard, and also with respect to the delineation of the therapeutic range of a disorder. Boundaries between different disorders and between the manifestation or non-manifestation of disorders are believed to be "fuzzy". In this sense, as noted by Poland et al. (1996) the DSM's approach is not 'strictly' categorical.

The issue of whether the categorical model is the best way to conceptualise mental disorders has been widely discussed. In recent years there has been burgeoning interest in the prospect of adopting a dimensional rather than a categorical approach (Widiger, 1992). Dimensional systems of classification assume that there are no dichotomies, groups or types. Rather, the symptoms of various mental disorders are thought to reflect quantitative deviations from normal functioning. This deviation is measured along a number of different dimensions, such as affective stability and anxiety. Proponents of this approach to the classification of psychopathology claim that present systems, such as the DSM, employ arbitrary cut-off points (Clementz & Lacono, 1993). And they propose that diagnosis would be more accurate and effective if patients were, rather, rated along the continuums of a number of dimensions.<sup>11</sup>

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<sup>11</sup> Dimensional approaches to the delineation of mental disorder are discussed in more detail in the last chapter.

Whether or not the DSM is on the whole, an ideal or simply adequate classification system is not of primary concern here, although some of these issues will be discussed again in the final chapter. What I have attempted here, is not an in-depth analysis of the applicability or efficacy of the predominant contemporary approach, but rather a straightforward description of it. In order to gain an understanding of the utility of this approach in cross-cultural contexts it is first necessary to explain and elucidate its theoretical underpinnings. The following section looks at the intersection of classification and cross-cultural psychology.

## *CLASSIFICATION AND CULTURE*

As mentioned earlier, the classification of mental phenomena is difficult because the subject matter is complex and diverse, and difficult to measure. Rather than looking at biological structure or chemical reactions, the objects of psychiatric investigation might include a subjective report of a 'feeling' or a cognitive state. There are probably different ways of reporting the same emotion and similar ways of reporting different emotions, because people can feel, think, and behave differently in the advent of similar external and internal stimuli. Conversely, in the case of a chemical reaction, it is possible for all aspects of an event to be readily observable, resulting in an analysis which is representative of all possible occurrences of the same chemical process. For example if sodium hydroxide is combined with hydrochloric acid the resulting reaction produces sodium chloride and water. In a controlled environment the experimental outcome can be predicted with complete certainty. In contrast, when the subject of study is human behaviour such predictability is usually impossible.

However despite the complexity of 'mind'-related information and the idiosyncrasies that might accompany it, there is of course commonality. Human beings are physiologically very similar; we share similar historical backgrounds, as our ancestors were faced with the same basic challenges, such as acquiring food and getting along harmoniously with one another. All people developed language to communicate, all people experience emotion, and all people can think. Admittedly these are quite broad assumptions; the commonalities probably run deeper. Hence a cross-culturally applicable

classification of mental disorders should be straightforward, if mental phenomena and the disturbance of them are expressions of this 'natural' and common heritage.

There are however strong social influences on many dimensions of human functioning. As the analysis of mental disorder in the previous chapter revealed, disorders also involve the disruption of socially determined norms. So a disorder has both physiological and social elements. A classification system which is utilised by a particular culture may therefore, to some extent, express the values of that culture. The inclusion of the disorder labelled depression, in the DSM-IV, suggests that this condition is devalued in western societies. However depressive symptomatology may not necessarily be viewed as disordered in other cultures. What is described here is the problem of relativity which is concisely expressed in the following statement by Schwartz and Wiggins: "We may say, then, that typifications provide only a perspectival apprehension of realities" (Schwartz and Wiggins, 1987, p.72).

The way in which the world is conceptually carved up is dependant not only on 'hard' data but also on socially embedded objectives. What is deemed typical of an object or phenomenon is contingent upon the perspective of the decision makers. Accordingly it can be argued that those involved in classifying mental disorders in the West have a particular perspective which is representative of Western culture. Even if depression exists in other cultures, it may not manifest itself in the same way. The symptoms, including subjective understandings of the problem, could be different. The proposition here is that different symptoms could signify the same underlying disorder. This raises the question of whether it is conceptually possible for a disorder to have different symptoms considering that it is generally the symptoms themselves which signify or delineate the disorder. Furthermore, symptoms which are in fact alike across diverse cultural contexts may be interpreted dissimilarly by different cultures yielding different "perspectival apprehensions".

Psychological phenomena may vary or show similarity at different levels. What is similar at the physiological level may vary at the behavioural or social level. This is because people can react to physiological and environmental stimuli in a variety of ways, according to societal expectations and etiquette. It is important when discussing

mental disorder to be aware of multilevel functioning and avoid generalising from one level to another. In a discussion of the heterogeneity of schizophrenia Tsuang et al (1990) presented several models showing the different levels of functioning which may be involved in this disorder. The discussion which was primarily oriented toward answering the question of whether schizophrenia is actually one disorder or a combination of several, proposed the view that heterogeneity at one level does not necessarily signify heterogeneity at another. What is relevant to *this* discussion is the idea that a disorder can vary at different levels. The aforementioned article presents a number of models depicting the possible relationship between three levels of psychological variables, which are:

- Level 1 - etiology
- Level 2 - pathophysiology
- Level 3 - symptoms

Two of the proposals presented in Tsuang et al.'s analysis of possible models, are:

1. - that two different etiologies may utilise one common pathophysiological pathway 'enroute' to symptomatology.
2. - that two different etiologies may be similar pathophysiological but have some exclusive and some divergent symptoms.

These suppositional models are presented as a framework for, developing understanding of schizophrenia, and planning investigations of it. It is likely that the same sort of model will be useful in the understanding of cross-cultural differences in psychopathology. In this case the addition of a fourth level may render it more appropriate. This level would be called something like 'socio-interpretal' and would refer to the interpretation and understanding of symptoms by particular social groups. This level allows for the possibility that symptoms of a particular disorder could be similar across cultures, but that the way the symptoms are understood could vary cross-culturally.

Similarly Kapur (1987) states:

Human mind and behaviour are very complicated phenomena; at whatever level we examine these, a variety of patterns can give rise to the same experience and many different kinds of experiences may be related to the same pattern depending on how it relates to other patterns which exist at that particular level at that particular phase in the person's life.

Here again is the idea that one level of explanation does not map directly on to another. Rather different phenomena at one level may give rise to similar phenomena at another. Figure 2. shows Kapur's illustration of this proposed view of the connection between phenomena at different levels of analysis. Depicted are three neurotransmitters, NT1, NT2 & NT3. In this diagram, three different neurotransmitters have led to seven different types of distress experience. What is important here is the pattern of connections between various neurotransmitters. Kapur proposes that the symptom response produced by a particular neurochemical change, will depend on its interaction with other neurochemicals within the same system. In this way, a specific phenomenon at one level may give rise to a quite different phenomenon at another.

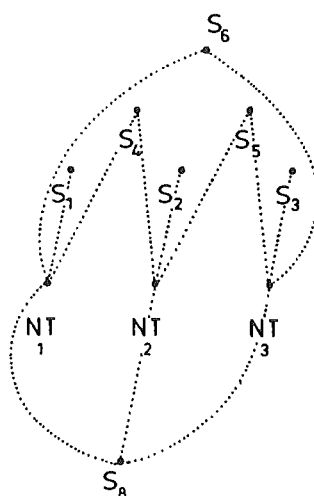


Figure 2. Diagram showing three neurotransmitters producing seven types of distress experience.<sup>12</sup>

<sup>12</sup> This diagram has been copied from Kapur (1987, p. 45). Kapur suggests that a more accurate representation of the phenomenon would require a multidimensional image. Note the number eight at the lowest point of the diagram, which should read seven. (The misprint is in the original).

What I want to emphasise here, is the difficulty that classificatory systems face in dealing with multilevel phenomena. An analysis of one level may reveal very little about another. As explained in detail in the previous chapter, mental disorders exist in a social context. If social contexts vary then it is possible or perhaps even likely that mental disorders will vary cross-culturally. Using the proposed four level model (i.e. the modified version of Tsuang's model), as a framework for understanding this variance, it is interesting and potentially revealing to ponder the depth of the differences. Perhaps similar events at the pathophysiological level could lead to quite different symptom patterns, as symptoms are more likely to be influenced by social value and expectation. For instance, in response to a stressful event a person in community 'x' could exhibit neurochemical changes and feel dysphoric and become withdrawn. In community 'y', however, the same stressful event could lead to the same pathophysiological changes and feelings, but the person could become aggressive. Obviously these sorts of differences could just as easily occur in two people from the same social group, the point though, is that symptom behaviour is shaped by socialisation in the same way that any behaviour is. Even though it is likely to be less controlled and purposeful it is still affected by the cultural context.

Nikelly (1992) states: "Social class and culture influence how emotional distress is expressed". This is exactly the point. As psychopathology is often a response to environmental stressors, it is therefore, according to this view, obvious that different social groups will exhibit distinct symptomatological responses. It may appear that this argument involves the implicit assumption that lower level phenomena are most important with regard to the identification of a disorder and that they are more likely to be similar across cultures - as my example shows that this level is stable across differing social environments. This however is not the intention. No one level is believed to be more important than any other, in this regard.

The problem of applying a predominantly mono-cultural classification system to persons of other cultures is openly acknowledged by the DSM-IV:

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is

unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief or experience that are particular to the individual's culture. (APA, 1994, p. xxiv).

As noted here it is necessary, in the case of a cross-cultural diagnosis, for the clinician to familiarise him or herself with aspects of the client's culture. In many North American Indian tribes it is common to experience hearing voices of spirits calling from the spiritual realm to those who are living, after the death of a loved one. This experience is considered to be a normal part of the bereavement process (Kleinman, 1988). This experience moreover, is not related to any subsequent problems, hence it would be a mistake to interpret it as psychotic. This illustrates Wakefield's view that mental disorders are significantly affected by social factors. Hence a classification system which categorises mental disorders according to the values of one particular culture will be of limited use in a cross-cultural diagnostic setting. The solution, as suggested in the DSM-IV, is that the clinician should learn as much as possible about the client's culture, and be sympathetic and sensitive to alternative ways of experiencing and understanding. This approach is supported by Nikelly (1992) who claims that in order to understand and diagnose 'subjective distress' and 'social impairment' one should be familiar with the 'language, symbols, beliefs, and values' which influence the person's attitude and reaction to stress. The DSM-IV includes a section on culture-specific disorders which should enable psychologists to recognise unique conditions and acknowledge the specificity and relativity of western diagnostic categories.

The theoretical foundations of classification shed light on some of the issues which arise in cross-cultural psychology. As expressed in the previous section, the utilisation of theory, plays a vital role in the categorisation process. The basis of the classification system, which is dominated by logical empiricism shows the importance of both empirical and theoretical data. The analysis of categorisation and its use of similarity reiterated this point. With regard to the present discussion it should be noted that observable or empirical phenomena are apportioned according to theoretical and conceptual systems. Hence it is conceivable that there are other ways of categorising the phenomena. This is stated with the acknowledgement in mind, that such systems are often measured in terms of their utility. What may be valued on utilitarian grounds, in

one culture, may not be in another. Other cultures may have other ways of dividing up psychological data, yielding different but equally efficacious classification systems.

It should be noted that the effects of classification systems are not limited to the clinical arena. Most people in Western societies would have some knowledge of major diagnostic categories and the symptoms which comprise them. Subsequently, behaviour, and specifically disordered behaviour may be influenced by the professional view. One wonders whether conditions such as anorexia nervosa would be as rife as they are today if they received less attention from the media. Perhaps widespread awareness of such conditions contributes to their manifestation; that is, individuals may be prompted, consciously or otherwise towards a certain type of pathological behaviour. Investigating the stereotypes of mental illness, Schoeneman, Segerstrom, Griffin and Gresham (1993) state in their conclusion: "...that category knowledge can be possessed by and affect the behaviour of those who are categorised as well as those who apply categories to others" (p. 450).

There is an important and complex interaction between popular and professional understandings of psychopathology. Commenting on this interaction Schoeneman et al. claim that both are "are products of social discourse" (p. 451). It is a dynamic two-way relationship between social convention and expert understanding which determines both popular and professional views on mental disorder. Arguably then, the bio-medical approach with its related thesis of universality can be challenged. If mental disorders are to some extent culturally embedded then diagnostic labels may not indicate disease entities.

Stein (1993) states: "Cross-cultural psychiatry serves to focus us self-reflexively on the limitations of our nosology, but also provides a challenge to understanding the universality of psychiatric disorders" (p. 328). In the following chapters the cultural dimension of mental disorder is investigated and the DSM's approach to the consideration of this dimension is evaluated.



## *SUMMARY*

The classification of psychopathology is clearly a more complex task than the classification of biological entities such as trees and butterflies. Primarily the difference lies in the number and types of variables that must be considered. While the latter simply involves the analysis of phylogenetic relationships, the former must include the analysis of psychological, biological and socio-cultural variables. What makes the taxonomy of living things relatively straightforward is that there is a clear object of study and in the case of psychopathology there is no clearly delineated object of this sort. The boundaries between disorder and non-disorder and between various disorders are not sharply defined but rather indeterminate and subject to change. Hence the process of classification involves not only the categorisation of entities but also the detection of those entities.

*PART TWO*

*THE*

*CROSS-CULTURAL*

*LITERATURE*

## CHAPTER 3

# *THE WESTERN APPROACH TO CROSS-CULTURAL ISSUES: AN HISTORICAL VIEW*

Many aspects of psychological research and understanding are complex, involving problems which are unique to this particular scientific realm. The brain may be one of the last great mysteries of our proximal universe. Along with quantum physics and dark matter, 'mind' and the intricacies of its structure and content, remains intriguing after many years of resolute investigation. And it is not that this investigation has been unsuccessful. Much has been discovered and theories surrounding these discoveries abound. But, as anyone studying this field will know, there are many obstacles. Many of these difficulties revolve around the fact that there are different levels of explanation. And the boundaries between these levels and the way that these levels interact, is unclear. There are physiological explanations, subjective explanations, social explanations and genetic explanations (to name a few), all offering plausible yet often incompatible narratives about human mental phenomena. Cross-cultural psychology traverses all four of these domains with the central question of: To what extent is human psychology and its pathologies a product of biological and/or social variables? And more precisely: Do mental disorders as judged by Western psychiatric diagnostic systems occur in other cultures?

While these are important and perhaps fundamental questions, it was not until recently that they were being seriously addressed within psychology (Kulhara, Mattoo, Awasthi & Chandiramani, 1987). Cross-cultural psychology, then, is a relatively new discipline. However, cross-cultural issues within science and society have a long and interesting history. Looking at these issues reveals how attitudes within both the academic and lay person's worlds have contributed to the conception of cross-cultural topics within psychology. Although one may discuss scientific views as if they are necessarily devoid

of social influence, this is often more likely to be an ideal, than a realistic appraisal. The interaction between social and scientific realms is profound and highly complex and often researchers have approached the understanding of this interaction with the view that one must sit on one or other side of the fence. Needless to say, this approach is naive. It is more productive to acknowledge their inextricable ties and admit that each impacts on the other. Obviously this is especially true in the domain of the social sciences.

Looking at the history of cross-cultural psychology in terms of this interaction is interesting and illuminating. One can clearly see that the western world has emerged from a much darker age which relied on prejudiced ideation to justify a predominantly intolerant and self-satisfying perception of cross-cultural variation, in psychology. Not that this metamorphic enlightenment is necessarily complete - far from it - but it is encouraging to look back through time and notice that beliefs about cultural diversity have changed in a positive direction. As mentioned previously, last century diagnostic manuals included a disorder called 'drapetomania' which was applied to slaves who ran away from their masters (Szasz, 1971, Wakefield, 1992). And more recently homosexuality was believed to be a mental disorder requiring correction. These examples suggest a significant connection between the science of diagnosis and classification, and societal factors.

## *DEFINITIONS*

The manifestation and influence of society is usually expressed in terms of 'culture' while genetic or biological factors are captured by the notion of 'race'. The related concept of 'ethnicity' may be connected to either of these terms. At times it is used to suggest racial affiliations and at other times political ones, which may or may not correlate with the former (Lock, 1993).

A thoughtful discussion of the concept of race is offered by Lock (1993). Primarily she questions the validity of the term which on examination seems problematical. As she explains, the notion of race was first introduced in 1749 by a French scientist, who qualified his proposal with the comment that it was not intended as a scientific

delineation but rather as a convenient classification for pragmatic purposes. His system of taxonomy was based on differentiations of skin colour, and the shape of the face and skull. The practice of devising taxonomies of human kind proved popular with numerous different approaches presented throughout the 18th and 19th centuries. As explained by Lock, some researchers have suggested that the appearance of the concept of race was associated with the rise of capitalist economies and the subsequent exploitation of indigenous people by European colonists. During this time, theories of race commonly expressed beliefs of white superiority which were associated with Christian doctrines alleging that dark skinned people were those who had degenerated since their dispersal from the Garden of Eden.

According to Lock, if the concept of race is to be scientifically sanctioned, races must be seen as sub-species of *Homo sapiens*. But few have decided that this is an appropriate analysis. Gould (1978) describes this as an outdated approach to within-species differentiation. In support of his claim Gould describes the striking genetic similarities between so-called races. Relatedly, with regard to so-called racial conflict Pedersen (1993) states: "Conflict between different ethnic groups may have less to do with their different ethnicities and more to do with difference of age, gender, socio-economic status, or many other affiliations" (p. 29). Pedersen's comment highlights the danger in generalising about between-group differences. In cases where race appears to be instrumental in differentiating populations, there may be other corresponding differences which are equally (or more) important in relation to the particular phenomenon in question.

With regard to health research, Lock notes that there has been a significant increase in the use of both race and ethnicity as independent variables. However the definitions of both are still debated. One important problem is that many people with mixed ancestry change their racial identity over time and often it is simply self-report which delineates people for research purposes. As Lock asks: "How white is white?" Questionnaires commonly ask people to categorise themselves according to one ethnic group or another leading to an artificially simplistic picture of racial identity. It is important to note such complexities when discussing cross-cultural studies as issues concerning the concepts of race and ethnic identity are often ignored. When comparisons are made between say

Euro-Americans and Afro-Americans it is useful to note the particular criteria employed for category membership.

The concept of culture, although broader and richer is none-the-less easier to define. There is agreement, at least, that whatever it refers to is worthy of such a label. One enduring definition was provided by Tyler (1871), who described it as: "That complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Brislin, 1990). This definition captures the impressive scope of the concept. According to Tyler culture is *everything* which comes about through the social interaction of human beings. Herskovits (1948) defined culture as that aspect of the environment which is created by people. This view refers to the external dimension of culture which includes such things as houses and automobiles. Less tangible are the constituents of what Triandis (1972) labels subjective culture, such as beliefs, values and norms. Similarly for Fabrega (1992), culture means, "a system of meanings that is learned, that provides people with a distinctive sense of reality and which helps shape behaviour and affective responses" (p. 91).

Brislin (1990, p. 12) writes: "Culture is indicated by ideas that are transmitted generation to generation, rarely with explicit instruction, by members of the older generations." Obviously the ability to fit into and typify a particular culture is not innate. Helman (1990, p. 3) states: "Growing up within any society is a form of *enculturation*, whereby the individual slowly acquires the cultural 'lens' of that society. Without such a shared perception of the world, both the cohesion and the continuity of any human group would be impossible". Culture provides people with a framework within which they can relate to one another and co-exist. And through language, people learn a particular mode of understanding and interpreting the world - a mode which is common to all and which therefore facilitates communication.

Like all other species of animal, *Homo sapiens* are born with a particular genetic and neurological make-up. This blueprint consists in a myriad of capabilities which may or may not be realised during an individual's life. It is commonly argued that whether or not these capacities are realised and the way in which they are, depends on environmental factors. For instance an animal that is raised in captivity may exhibit a

behaviour repertoire which is very different to that of its counterparts in the wild. Different environments favour or bring-out different behaviours. In a valuable explication on cultural psychology Schweder and Sullivan (1993) state "...that cultural learning is usefully conceptualised as the refashioning of what is inherited, prior, built-in, or given. In human beings as in other species, learning processes are not incompatible with the existence of an inherited system of complex forms" (p. 512). And, "Cultural learning does not presuppose an empty organism" (p. 513). Culture is shaped in part by innate dispositions. An acknowledgement of culture does not entail a denial of biology. The activities that people engage in are a function of their physical form and their mental abilities, which have arisen through evolutionary pressures. Culture is sometimes presented as divorced from such variables but it is rather built on them. While the importance of socio-cultural factors will be highlighted in forthcoming arguments, there will be an implicit understanding of the underlying influence of organic forces.

It should be noted that there are innate differences as well as innate similarities. Although biology and physiology are often presented (in this theoretical area) as creators of uniformity (Patel & Winston, 1994) this view is yet to be established. Despite striking similarities at the biological level there is also diversity. Such diversity is fundamental to the process of evolution (Darwin, 1859). It is important to recognise this point, especially when discussions of cross-cultural issues allude to underlying physical processes as examples of universality.

Discussions of culture traverse many domains: sociology, anthropology, psychology, history, and others. Culture permeates and is permeated by numerous aspects of human existence. One of the main difficulties for investigators of culture is the fact that they too are permeated by that which they are attempting to study. When one studies another culture it is perhaps always in comparison to one's own. As the following section shows, early cross-cultural understanding in the modern world was dogged by problems of relativism and short-sightedness.

## *ETHNOCENTRISM AND PRIMITIVISM*

The history of the Western approach to cross-cultural issues has been dominated by ethnocentrism (Skultans, 1991). And it is not surprising; before the communication boom of the 20th century there were substantial barriers between many of the peoples and nations of the world. One can argue that unfamiliarity often leads to fear which in turn leads to the development of antagonistic beliefs and behaviours. This analysis may seem simplistic but on the other hand, it acknowledges the massive changes which have taken place over the past century. Isolation and ignorance foster ethnocentric beliefs which arise in part out of a desire to protect and promote the wellbeing of ones own people; a desire which is rooted in human evolution (Wilson, 1975). Hostility towards foreigners which was often in the form of genocide, has been an integral part of political life for many societies (Diamond, 1991). For example, as powers such as the Roman and British empires sought to broaden their territories, indigenous peoples were exploited, enslaved and often killed. This sort of barbarism fed on ethnocentric philosophies which sought justification in political and religious doctrines. As a matter of interest, the word barbarian has a surprising origin. It is derived from the Greek word 'barbaroi' which was used to refer to people who were unfamiliar with the Greek language (Lucas & Barrett, 1995) and instead frequently uttered an unintelligible chatter which sounded like 'barbar' (Triandis, 1990). Hence the term 'Barbarian' arose to describe a race who were allegedly inferior because they spoke another language.

In the centuries, leading up to the last two millennia and immediately following the supposed birth of Christ, many Greek philosophers exhibited ethnocentric ideas. Much of this was probably related to their support of slavery which was an integral part of life in early Greek society (Fernando, 1988). The Greeks tended to view themselves as 'civilised' in contrast to other less advanced societies, and hence slavery was seen as morally acceptable because it exposed the foreigners to a better way of living. The early Greek philosophers are perhaps best known for their love of the intellect, or rational mind which was often claimed to be lacking in animals, women and savages ( as in Aristotle's *Politics I*).



This sort of reasoning was also seen in the philosophy which supported the expansion of the British Empire. In Britain during the 15th and 16th centuries, information about Africa was interpreted according to the prevailing folklore about black people (Fernando, 1988). But such ideas date back much further. A musical work composed in the second century AD, called 'Epistle of Barnabas' referred to blacks as being 'born of the devil' (Fryer, 1984). The association of black people with the devil was commonly seen. It probably arose from Christian views on the correlation of white with moral purity and black with evil and darkness. In fact the old testament suggests that dark skinned people were created separately as a stepping stone between apes and man (Fryer, 1984).

More recently, the prominent 18th Century British philosopher David Hume wrote:

I am apt to suspect the Negroes, and in general all the other species of men (for there are four or five different kinds) to be naturally inferior to whites. There never was a civilised nation of any complexion other than white, nor even any individual eminent either in action or speculation. No ingenious manufacture amongst them, no arts, no sciences. On the other hand, the most rude and barbarous of the white, such as the ancient GERMANS, the present TARTARS, have still something eminent about them, in their valour, form of government, or some other particular. (Hume, 1753; from Fernando 1988, p. 10)

This excerpt gives a useful indication of the sort of thinking which was common (even among intellectuals) only two centuries ago. Note that even the less advanced 'white' cultures were seen as superior to their black equivalents. Apart from the obvious prejudice, Hume's claim is now known to be factually wrong. The ancient Egyptians who are now believed to have been African Negroes, were the most technically advanced and complex society in the world at that time. Of course anthropologists have known this, or at least suspected it for centuries, however the idea was not well received as it was clearly inconsistent with contemporary beliefs about black people.

Politicians and migrants needed a means of justifying the immense desecration of indigenous societies by various colonies. This usually hinged on the view that ultimately these allegedly less developed countries would benefit from the invasion. Colonists brought with them such things as guns and Christianity which were

considered adequate payment for the destruction of the world as native peoples had known it. In Bengal, many Indians starved as Britain took control of its industries. Britain wanted cheap labour for its own production lines and a market for its goods. As the old Bengal crumbled, wealth from this and other offshore exploits fuelled the industrial revolution in Britain (Fernando, 1988).

Early in the 19th century the slave trade in Britain was abolished, however slavery remained an important part of British colonialism. Following the disruption, and in some cases desecration of the social, political and environmental infrastructures of indigenous societies, native peoples become dependant on the invading culture for their livelihoods, leaving them open to exploitation, which the British were quick to take advantage of. This imbalance of power fuelled beliefs about the inferiority of indigenous people; they were often unable to function effectively in the rapidly changing environment. This phenomenon is still seen today. Even in New Zealand which was colonised over 100 years ago, some Maori people still experience a sense of displacement (Hazlehurst, 1993).

The treatment of the Maori by British colonialists was typical of their dealings with so-called primitive peoples. Primitivism was the ultimate justification for exploitation, because the knowledge and technology which the British supposedly brought to the indigenous people were seen as priceless gifts which would lead them out of moral and epistemological darkness. Lucas and Barrett (1995) have looked in detail at primitivist themes in psychiatry. Generally, they explain, two opposing perspectives have been used: Barbaric and Arcadian. The Barbaric view sees primitive societies as degenerative, disruptive and mentally pathological. In contrast, the Arcadian view equates primitive societies with purity, harmony and well-being. Lucas and Barrett state, "As a presence within the Western self, the primitive may be either an instinctual disordering force which erupts as violence or madness, or alternatively, a wellspring of order which places us in harmonious and healthy touch with nature and our 'true selves'," (p. 290).

Relatedly these two interpretations of primitivism can be seen as either conducive to or curative of mental disorder. The Barbaric mind is described as lacking intellectual capacity and order, hence it is prone to irrationality and impulsivity - primary-symptoms

of some Western psychopathologies. On the other hand, the Arcadian mind is seen as simple and balanced - in touch with nature and uncontaminated by the artificialities of modern life. In this way it is viewed as healthy and harmonious. For example Seligman (1929) stated that he observed 'no cases of true mental disorder' among native Papuans, whereas in support of the antithesis, Kraepelin stated that primitive societies provided 'natural laboratories for the study of insanity' (Hirsch & Shepherd, 1974).

As stated by Lucas and Barrett the association of primitivism with psychopathology is fundamental to Western psychiatry. Mental disorder is often understood as 'an upsurge of the primitive within us.' According to this view, higher cognitive functions which usually have a controlling effect, give way to more basic and perhaps animalistic influences. For instance, Andreasen (1990) suggests that the positive symptoms of schizophrenia correspond to the overactivity of lower 'perhaps limbic' mechanisms which are insufficiently monitored by higher cognitive functions. This view is demonstrated also by psychoanalytic theory. Freud (1950) suggested that there are similarities between the psychology of people in primitive societies and the repressed and unconscious components of the minds of 'civilised' human beings (which are often consequential during mental illness). And Jung alerted so-called civilised beings to the danger of associating with 'inferior man' whom he claimed could have a powerful effect on their psyches - stimulating their primal minds and tempting them to degenerate to lower forms of living (Fernando, 1988).

Skultans (1991) writes, "So contact with primitive man is seen as disrupting the delicate balancing act required for civilised society because primitive man embodies the untrammelled expression of desires repressed in his civilised counterpart." Fortunately, as noted by Skultans such ideas are now thought to say more about the theorists than about their 'objects' of study.

## WESTERN DOMINANCE

What this discussion shows, is that the British, among others, have a history of a discriminatory approach to cross-cultural understanding. It must be noted that it was in this socio-political environment that cross-cultural psychology developed. The typical

colonising process of stamping out indigenous traditions may be reflected in Western views on mental and physical health. Often these ideas become so commonplace and so ingrained that laypeople and even educated researchers are unaware of their presence. There is undoubtedly a tendency for those in developed countries to view themselves and their beliefs as superior. English speakers dominate the world. America is the wealthiest nation. White people landed on the moon. Technological advancement such as that evidenced in Japan may overshadow the knowledge system which this country had prior to European influences. While Japan's modern day achievements are held in high regard throughout the world, their original culture is less conspicuous. In the modern world, economic strength is everything and to attain this, compromise seems inevitable. The technological and economic achievements of powerful countries overshadow the more subtle accomplishments of the lesser (economically) developed nations.

For example there are tremendous depths of knowledge to be found in Indian, Tibetan and Chinese religious doctrines. Zen Buddhism, for instance, which has its origins in both India and China, preaches the benefits of having a clear 'mind', or more precisely 'no mind'. This is attained through meditation with the ultimate goal of enlightenment. Learning to be aware, without the constraints of beliefs and cognitive habits which have occurred through socialisation, is believed to create a more objective and direct perception. It is a process of uncluttering the mind which is claimed to lead to both mental and physical well-being (Barrett, 1993).<sup>1</sup> An holistic understanding of the relationship between mind and body is common throughout Asia, and has an important influence on healing practices.

Many cultures, for instance, North American Indian, Asiatic Indian and Chinese have very effective and complex methods for treating mental and physical disease in human beings. These are often methods with a longer history than those commonly used in Western countries (Fabrega, 1992). Because they usually have their roots in quite different theoretical beliefs, these systems of understanding are often ignored or criticised by the supposedly 'scientific' West. However, it is interesting to note that some of these 'foreign' techniques are becoming popular in New Zealand and many

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<sup>1</sup> This is undoubtedly a very brief and simplistic description of these ideas which does them no justice whatsoever. However some of these ideas will be discussed in more detail in the next chapter.

other Anglo-dominated countries. A case in point is acupuncture, which although based on comparatively radical theories of physiological functioning, is an accepted and widely used treatment for some physical disorders.

The efficacy of such physical treatments is easier to measure than that of mental therapies. Perhaps that is why little is known of the latter. Although there is increasing acknowledgement of mental disorders which are culture-specific (known as culture-bound syndromes), such as evidenced in the latest DSM, information on culture-specific approaches to the understanding and treatment of mental illness is sparse. Such investigation is probably left to anthropologists whose work is often discredited because of its qualitative style. It is to be hoped that more work will be done in this field in the future.

### *EARLY CROSS-CULTURAL PSYCHOLOGY*

Although the question of the universality of mental disorders has been of interest to psychologists for years, early cross-cultural studies of mental health were not impressive.<sup>2</sup> This is primarily because it was, until recently, a field in its infancy, establishing the ground rules as it went along. There is nothing inherently wrong with this approach, but it does mean that little can be drawn from the results and conclusions of this early research. Many cite Kraepelin's 1919 study on schizophrenia in Asia as the first significant cross-cultural investigation. Kraepelin boldly concluded after examining hospitalised patients in Indonesia and Singapore, that Schizophrenia is a universal disease (Torrey, 1973). About 20 years prior to this work (in 1897), Durkheim investigated the cross-cultural epidemiology of suicide (Berrios & Mohanna, 1990). He was interested in the relationship between rates of suicide and various societal variables. However the originality of the study was not matched by the quality of the methodological design hence the result was more like a social commentary than a scientific investigation.

In 1932, Odegaard carried out unprecedented research on psychiatric admissions of Norwegians in their homeland, and in the United States (Westermeyer, 1989), and from

then on the field gained momentum with a sudden upsurge in interest in related topics. What seems to have been most important to researchers of this period was the question of the nature and extent of mental illness in so-called primitive people. For some it was simply another means of confirming their ethnocentric views. For instance, Carothers (1951) stated that "...all the observed African peculiarities can be explained as due to a relative idleness of his frontal lobe." And Smartt (1956) asserted that "...The African seems in some way, to be lacking the higher moral sense which is the heritage of more advanced civilisations." (Both quotes from Torrey, 1973, p 55 & 56). Unfortunately these sorts of vague generalisations were common in the field at this time. Apart from the racist overtones they express little else. The narrow-mindedness of these Western intellectuals is embarrassing and does no credit whatsoever to the establishment from which they have arisen. Although objectivity has improved in recent decades, it would be wise to note that when these statements were made they were relatively well received. So while our cross-cultural acceptance may have expanded, it may be difficult to ascertain exactly how much. We may all be wearing tinted spectacles (metaphorically speaking), similar to those described in Roger McGough's poem, "Patriots are a bit nuts in the head."<sup>3</sup>

It is worth noting the changes which have taken place throughout the 20th Century. As mentioned, advances in communication have had a tremendous impact on most people of the world. They have in a sense made the world a much smaller place. We are exposed to images of other cultures via television and magazines and it is easy to travel to far and foreign destinations. These changes have had a positive influence. Familiarity contributes to a greater understanding of, and empathy for, other cultural groups. There is also greater racial diversity in our own domestic environment which creates more ways and means of increasing knowledge of other races. On the other hand, these ways and means are not always exploited and many New Zealanders may retain old fashioned discriminatory views.

The relationship between, beliefs manifest in the everyday activities of communities and, the so-called knowledge accrued through scientific endeavour is complex. Each

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<sup>2</sup> The terms psychology/psychologist and psychiatry/psychiatrist will be used interchangeably as the issues in question and the related literature concerns both fields.

influences the other, in ways that are at times so subtle that it would appear that there is no such relationship. That is because the people investigating the relationship are usually part of that relationship and hence objectivity is an impossible goal. It appears that over the years, beliefs about cultural diversity have changed both within science and within the world as a whole, leading to greater acceptance and less racially based discrimination. Whether this process of enlightenment has reached an end point is debatable. Investigators in this area must be wary of the possibility that they are still influenced by the racist ideologies that have strongly influenced cross-cultural relations for most of the past two millennia. And one must not assume that scientific endeavour is impervious to the effects of these ideologies.

### THEORETICAL SHIFTS

Recent years (meaning the latter half of this century) have seen a fundamental shift in the focus of psychology from behaviourism to cognitivism (Pepitone, 1986). Insofar as this represents a change from an outward to an inward focus, this parallels a metatheoretical move from positivist to hermeneutic perspectives. Positivism sees knowledge as hinging solely on worldly and usually observable phenomena. What is considered to be true is that which corresponds to objects, and the relations between objects, in the physical realm. Hence, positivists see physics as the best model for their view of science (Stein, 1991). In contrast the hermeneutic tradition focuses on the role of subjective understanding in epistemological endeavours. Essential to this approach is the part that meaning plays in theory development. Hence there is a strong focus on language and the impact of factors such as, *agency* and *context*.

In light of this transition it is not surprising that there has been growing interest in cross-cultural psychology. Not that this has been a movement that has caught the imagination of all inquiring psychologists. Many uphold strongly positivist positions which as will be illustrated in forthcoming chapters, have influenced and still influence cross-cultural research. But one can not deny the fact that even if one aspires to objectivist methods of investigation, such methods are difficult in the domain of psychology. For instance, Freud's theories of human behaviour are best understood with reference to the context

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<sup>3</sup> In this poem Roger McGough describes patriots as wearing "...red, white and blue tinted spectacles

in which they arose. Although Freud may have claimed to have built his theory on robust empirical investigation, it is clear in retrospect that its scope was more limited than Freud himself believed. And to make a different and perhaps more pertinent point, psychiatric diagnoses frequently refer to subjective data. Self-report is something that can be observed by a clinician, however the hard data involved in this context are a product of the thoughts, feelings and intentions of the client. While social sciences may aspire to positivist ideals they are inevitably constrained by their objects of study, from which they get their identity, and this should not be a moot point.

So, interest in cross-cultural issues has increased. Many psychologists have realised that there are differences in the way that mental disorders manifest in different ethnic groups and environments (Littlewood, 1990; Schweder & Sullivan, 1993). These differences may be realised at the levels of, neurobiology, physiology, subjective experience and/or behaviour. Researchers who favour positivist explanations of mental disorder often claim that differences found across cultures may reflect similar underlying pathophysiology. In other words, the same disorder may have a number of subtly varying manifestations which have the same etiology and neurobiological correlates. A more radical positivist view is that all disorders are in fact alike and any reports to the contrary are simply products of bad research wherein investigators have been hindered by cultural barriers such as differences in language and customs. These views would come under what Littlewood refers to as the 'old transcultural psychiatry' which as he explains began with Kraepelin's work early this century. Central to this approach is the assumption that differences are inherently superficial and when peeled away they reveal deep similarities which are evidenced in universal physiology. For instance the content of delusions in schizophrenia may differ across societies but their essential nature and underlying etiology will remain uniform. "Thus when faced with patients of different culture, psychiatrists complained (and still do) of the 'culturally confusing' factors which obscured the 'real' disease process." (Littlewood, p. 309).

So according to this account culture is seen as a nuisance variable which obscures the more fundamental features of mental disorder. Littlewood contrasts this view with the 'new cross-cultural psychiatry' which began in the late 1970s. This approach sees

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(red for blood, white for glory and blue for a boy)."



psychiatry as a cultural product which expresses predominantly Western beliefs and values. Central to this new field are epistemological issues which were often ignored by the 'old' tradition. These include questions about the suitability of particular methodologies in cross-cultural research and the nature of mental disorder.

Kleinman, a key proponent of the 'new' psychiatry suggested the use of the distinction between disease and illness; a distinction which is already used by sociologists (Kleinman, 1978). Disease in this instance denotes biological or physiological malfunction and illness the personal or cultural response to disease. A primary function of this distinction is the acknowledgement of the role that personal and cultural variables play in psychopathology. The 'old' psychiatric tradition with its narrow medical model could not incorporate such variables and hence was (and is) cumbersome in cross-cultural contexts. The inclusion in the DSM IV of a list of culture-bound syndromes suggests that there is widespread acknowledgement of cross-cultural differences in psychopathology. However the addition of this section presupposes that all other disorders in the manual are in contrast universal. As if to say that disorders which arise in the West are immune to the confines of such a label. This belief may in part be due to the fact that Western culture has so permeated the far reaches of remote places that research has the added difficulty of studying people who have to some extent been acculturated. If anorexia nervosa is found in Indonesians it may be that it has been 'exported'. For some researchers however this sort of finding would be used to support the claim that anorexia nervosa has a pan-racial biological basis.

Interest in the biological bases of psychopathology has been spurred on by developments in psychopharmacology. The discovery and use of a variety of psychoactive drugs has had a big impact on contemporary conceptualisations of mental disorders. For example the success of antidepressants in the treatment of major depression and antipsychotics in the treatment of schizophrenia lends support to biological theories of these disorders. Such theories are consistent with the bio-medical model of psychopathology, outlined earlier, which views mental disorders as discrete entities or phenomena with clear physiological underpinnings (Kleinman, 1988). But of course it is erroneous to infer the nature of etiology from the effectiveness of a particular treatment. Interestingly research on a number of disorders suggests that a variety of treatments may be equally effective. For example a comprehensive study of

different treatment approaches to depression found no significant differences in comparative efficacy (Elkin, Parloff, Hadley, & Autry, 1985).

The use of drug treatments in psychiatry is now common world-wide. The domination of lesser developed nations by Western medicine is due largely to its success in the treatment and prevention of many diseases; particularly the effectiveness of vaccinations, such as that used for small pox (Leff, 1990). This had the effect of instilling the faith of many societies, in Western pharmacological therapies and perhaps also in psychopharmacological therapies. This faith should not be abused. Western psychiatry and psychology must heed the lessons of their chequered history of cross-cultural understanding and employ responsible clinical methods. According to Littleman this is already happening, however the extent and efficacy of these changes require examination. The following chapter will look closely at the approach of contemporary psychology to cross-cultural issues.

## SUMMARY

Historically, Western scientific and literary thought on cross-cultural issues has been plagued by ethnocentric attitudes; attitudes which were present also in early cross-cultural psychology. This led to a number of misguided assumptions about mental disorder in diverse ethnic groups, some of which might now be seen as simply comical. Early cross-cultural studies in psychology were also often poorly designed, demonstrating a lack of understanding of the requirements of inter-ethnic research. Fortunately changes in both attitudes and research methodologies mean that modern cross-cultural psychology produces more reliable findings.

Also there is today a deeper understanding of the significance in human existence of socio-cultural variables and a growing interest in their interaction with mental disorder. While this is heartening, it is important to be aware of the ethnocentrism which has dominated much of the not-so-distant past, and to remain alert to its possible on-going influence. The next chapter looks in detail at the scope of contemporary cross-cultural psychology.

## CHAPTER 4

# CROSS-CULTURAL APPROACHES TO MENTAL DISORDER

As the previous chapter illustrates, cross-cultural psychology embodies a diverse mix of topics and ideas. Since its inception (if one can call it that), although its identity has mutated in response to the vicissitudes of social and scientific thought, it has none-the-less chrystallised to form a distinct area of academic study. This claim must be qualified however, with the acknowledgement that it is an area of research which relies on the contribution of several disciplines. It was philosophy perhaps that first attended to questions regarding human diversity but as shown in the previous chapter, these early views were more a product of politics and religion than of science. Empirical research in cross-cultural psychology is a relatively recent phenomenon. During the last 50 years most of the research in the field has been carried out by psychiatrists and anthropologists. Those with training in both of these disciplines are often referred to as medical anthropologists. There have also been significant contributions from psychologists and sociologists. It seems that the differences in the theoretical approaches of the respective research programmes have been both a help and a hindrance. While there is obviously a need for an interdisciplinary approach this is rendered difficult by theoretical disparity between researchers.

This disparity can be seen primarily as the polarity of social versus biological explanations which dominates discussions of cross-cultural psychology. The first section of this chapter examines the many facets of this debate in detail, sketching a theoretical map of the field. Then there is a discussion of cross-cultural differences, suggesting some of the ways in which culture may be expressed through individual psychologies. This is demonstrated with some clinical examples which show the impact of social context on mental disorder and diagnosis. The last section discusses some of

the main issues which arise in the application of cross-cultural psychology in the contexts of both clinical practice and research.

## *UNIVERSALISM VERSUS RELATIVISM*

The introduction in the previous chapter, of the contrast between positivist and hermeneutic perspectives foreshadowed the present discussion. While the former focuses primarily on regularity the latter places an emphasis on diversity. These can be described as different epistemological approaches which correlate with the two dominant traditions within cross-cultural psychology: universalism and relativism (respectively). It is advantageous to note that a distinction of this sort may depict a too simplistic and hence misleading ontological view. Schweder and Sullivan (1993) include the 'universal vs. relative' distinction along with others such as 'innate vs. learned' and 'natural vs. cultural' in a list used to illustrate their claim that "...the social sciences are rife with invidious distinctions and divisive (and arguably false) dichotomies." (p. 505). Their central point is that the use of diametrically opposed concepts such as these, encourage the pigeonholing of ideas leading to gross misinterpretation. Peoples' views are often forced into one or other category. Many psychiatrists and psychologists would fall not in either category but rather somewhere in between. It is necessary however to attend to the universalist vs. relativist debate as it underpins much of the pertinent and pivotal literature.

Fabrega (1989) provides a comprehensive discourse on the nature and influence of these two opposing themes within psychiatry. He explains that universalists use the Western biomedical framework to find similarities across cultures. This approach which may also be referred to as 'etic', uses explicit standard diagnostic criteria to interpret and classify psychopathology in diverse populations. Typically protagonists of this cross-cultural investigative method are traditionally trained psychiatrists. Their central claim is that mental disorders as defined in Western taxonomies will have similar, if not identical, manifestations in all cultures because they are the result of physiological dysfunction and human beings around the globe share a common physiology. Hence the universal incidence of a mental disorder would be viewed as evidence of biological etiology (Patel & Winston, 1994). If social and cultural factors

vary across populations then it is assumed that similarity in psychopathology is due to genotypic similarity.

As explained by Patel and Winston, the quest for universality and (therefore) biological etiology represents a hope of validation of modern diagnostic systems. Psychiatry, like medicine seeks clearly defined illness categories which can be explained in terms of physiological or biological change and it is believed that cross-cultural research can contribute to this objective. In this sense universalists are more interested in their own culture than in the cultures of others. Non-Western populations are seen as testing grounds for Western ideas and it is only those variables within these populations, which are relevant to these ideas, which are taken into account.

In contrast the relativist or 'emic' researcher uses a qualitative or descriptive methodology with the aim of understanding psychopathology within the context of its manifestation. This usually demands a thorough knowledge of the culture of those who are being studied and is therefore characteristic of an anthropological approach. Fabrega states: "Cultural relativism refers to the differences in beliefs, feelings, behaviours, traditions, social practices, and technological arrangements that are found among diverse peoples of the world." (p. 415). The 'emic' researcher assumes that these cultural constituents may have a significant impact on mental disorder, meaning that if culture varies across societies there will be corresponding differences in psychopathology. Accordingly mental disorders are conceived, to varying extents, as social (as opposed to biological) phenomena.

In response to the universalist directive, relativists assert that diagnostic categories are essentially abstractions or constructions used to explain psychiatric phenomena within the context of Western culture and the Western medical tradition (Fabrega, 1989). Hence they are necessarily limited in their capacity to explain such phenomena in diverse settings. Moreover relativists question the merit of the practice of using a classification system devised in one culture for understanding psychopathology in a substantially different culture; because this sort of methodology places constraints on cross-cultural learning. If only those aspects of belief and behaviour that fit into the Western framework are noted, there will inevitably be much that is unseen or overlooked. Therefore the capacity for developing a deep and genuine understanding of

the nature of mental disorder in the context of a contrasting culture will be limited. And furthermore this approach may undermine indigenous knowledge systems.

In response to these criticisms universalists would point out that the 'lost' data are extraneous in the sense that they do not contribute to the confirmation or disconfirmation of the hypothesis of universality. Because at most, cultural factors simply colour the content of mental disorder without influencing the physiological cause or structure. As Kleinman (1987) explains, this is a common view within psychiatry and as he astutely notes it is reductionist. Cross-cultural variation in symptomatology is seen as superficial; as part of the outward appearance of disease while underlying biological change is seen as the disease itself. But of course this view is problematic as many disorders are defined by symptom patterns and not by physiological change. At this point in time although there are some biologically based theories of some mental disorders, this area of research can only be described as being in its infancy. And in addition, few theorists would posit purely biological theories. Most acknowledge biology's interaction with environmental factors and favour multi-dimensional models.

While there may be differences in symptomatology, those who follow the universalist directive, look for broad underlying similarity. So, the central question would be whether or not a person is delusional as opposed to an inquiry into the nature and content of the delusion. However even if a similar symptom pattern as that defined in, say, the DSM-IV, is found cross-culturally, this should not be interpreted *prima facie* as evidence that it is the same disorder. In the case of a somatic disorder this conclusion would require the discovery of a common 'pathology' (Patel & Winston, 1994), meaning a common physiological presentation. And if such pathology is considered central to mental disorder then surely psychiatrists involved in cross-cultural research should include biological measures as well as behavioural ones. Obviously this is a difficult requirement, but it is nonetheless essential if physiological mutation is to be seen as the essence of mental disorder.

Jovanovski (1995) discusses the field of ethnopsychiatry which has grown out of the 'psychocultural relativism' which was proposed and promoted during the 1930s by Ruth Benedict and Margaret Mead and during the 1940s by George Sapir. Central to

their common view is the claim that personality is inextricably tied to culture, because personality is shaped by language, thoughts and folklore. Their corresponding deduction therefore, is that mental disorders (which necessarily involve personality in one way or another) must be significantly (if not entirely) attributable to cultural variables. Importantly, ethnopsychiatrists advance a tenet of the primacy of conceptions of 'self', conceptions which they see as being moulded out of socio-cultural phenomena. And conceptions of 'self' are believed to play a key role in the manifestation of mental disorder.

Scheff (1966) provides as example of the ethnopsychiatrists' perspective. He proposes that behaviour during periods of insanity is shaped by stereotypes in the same way that so-called normal behaviour is. He states: "In a crisis, when the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery of action, both for those reacting to the deviant and, at times, for the deviant himself." (p. 82). The suggestion here is that people respond to mental disorder in prescribed ways and this response, in turn, affects the disorder. A more radical claim would be that the 'initial' presentation of the disorder would itself obey societal norms.

The relativist/universalist debate parallels the differences in approach between sociology and psychiatry. Cooper (1994) discusses the relationship between sociology and psychiatry in recent years and examines some of the central issues which arise at this intersection. He states, "...issues both of method and substance continue to divide the thinking of medical and social scientists, not least in the mental health field." (p. 39). Psychiatrists have moved towards the use of 'highly structured precoded schedules' which require brief interviewer instruction and can be analysed by computer. During the implementation of this sort of evaluation, attention to other patient-related data is discouraged. In contrast sociological researchers predominantly use 'semi-structured interview techniques' which allow for, and encourage, the inclusion of complex individual detail. Interviews of this kind require highly trained professionals who are able to discriminate between subtle variation in responding. Sociologists therefore take a more qualitative approach allowing greater scope for the embodiment of individual context-dependent variables.

Cooper argues that because mental disorder can not be explained solely in 'medico-psychological terms' but also with regard to social forces then it is essential to inquire into the nature of such forces. In other words it is important to investigate the rationale behind the stigmatisation of particular individuals and the prohibition of particular behaviours. Cooper sees this as an important role for sociology and social psychiatry. He says: "The pressure of social influences on case-recognition and diagnosis cannot be dismissed as of marginal importance." (p. 40). According to Cooper, social factors play a pivotal role in the process of psychiatric diagnosis. He goes further and claims: "Psychiatrists need always to keep in mind that 'mental illness' is essentially a social construction." (p. 40). It is apparent in his clarification of this statement that he does not intend to undermine the objectives of psychiatrists, but rather to remind them of their objectives. The ultimate goal is successful treatment, and diagnosis is the means to this end. It is not an end in itself and has no intrinsic value. A diagnostic label allows the communication and collection of relevant information and as such it is a useful tool. It is not an 'object' in the world like, for instance, a chair or a book. Rather it is part of a social epistemological system which has been formulated to achieve certain ends.

This is an important aspect of the relativist challenge to psychiatry. Approaches to the understanding of psychopathology should allow for the impact of social forces not only on mental disorders but also on relevant taxonomies. In other words a classification system such as the DSM-IV may be seen to reflect beliefs and ideals which are characteristic of Western culture and therefore may not be applicable in different cultural contexts. This particular relativist claim can be distinguished from the suggestion that the actual manifestation of psychopathology (i.e. psychological and physiological variables) may vary across cultures.

## *THE ARGUMENTS*

The discovery and use of a variety of psychoactive drugs has had a big impact on contemporary conceptualisations of mental disorders. In particular, it lends support to the argument that mental disorders are essentially the result of physiological malfunction. For example, the effectiveness of antipsychotic medication such as chlorpromazine has lent support to biological theories of schizophrenia. Such theories



typically utilise a medical model of psychopathology which views mental disorders as discrete entities with clear physiological correlates (Kleinman, 1988). But, as pointed out earlier, it is fallacious to reason that an effective treatment type points directly to an etiological counterpart. None-the-less there is no doubt that success in psychopharmacology has provided encouragement to those who are looking for cross-cultural universals. A major problem however is that researchers have failed to identify biological mechanisms to explain drug action.

And interestingly while psychopharmacological treatments have been widely used, some researchers have reported differential responding across ethnic groups. For example a number of studies have compared the response to psychotropics of Asian and Caucasian individuals. Differences between these ethnic groups have been found in the response to antidepressants (Lin, Poland & Lesser, 1986; Sakauye, 1992) and neuroleptics, lithium and benzodiazapines (Lin and Poland, 1995). Lin and Poland note that the causal mechanisms underlying these differences are as yet unknown, but are likely to involve both physiological and psychological factors. While this remains a new and largely uncharted area of research, such results challenge the view that with respect to the understanding and treatment of mental disorder human beings are physiologically equivalent.

Evolutionary based arguments which refer to phylogenetic similarity have also been used in support of the universalist position. One such argument claims that emotions operate according to 'fixed action patterns' which are essentially reflexive (Griffiths, 1990). As noted by Smith (1993), this view of the universality of emotion has been investigated through studies of facial expression. Such studies reveal that the facial expressions which correspond to particular emotions are primarily innate, with only slight cultural differentiation (Ekman & Friesman, 1971; Ekman 1992). It may be argued that if correlates of emotion such as facial expression exhibit universality due to common phylogeny then the mental mechanisms involved in emotion and their respective dysfunctions may also be ubiquitous.

However, there would appear to be more to emotion than neurophysiological phenomena. The human experience of emotion involves the invocation of cultural variables, especially language, which varies tremendously across peoples of the world.

While some theorists have promoted the thesis of universal ‘basic’ emotions, linguists, such as, most notably, Whorf (1950), have suggested that the so-called basic emotions are in fact artefacts of the English language. In a detailed analysis of emotion concepts across cultures Wierzbicka (1992) reviewed a number of linguistic differences between English and other languages which suggest that the ‘basic’ emotions as delineated by the English language do not designate lexical universals. The position of Wierzbicka and others is controversial but raises important issues. Language may not only shape the interpretation of emotion but also the emotion itself (if it is possible to distinguish between them), forming a complex psycholinguistic mode of experience. Some anthropological research lends support to this hypothesis (e.g. Lutz, 1985; Rosaldo, 1980).<sup>4</sup>

Turning to a quite different area of research, Jovanovski (1995) argued that findings in perceptual psychology lend support to the relativist position. He claimed that people raised in urban areas respond differently, to visual tests, to people who have grown up in rural areas. The former respond more readily to angular and structured stimuli whereas the latter show more sensitivity to less regular and perhaps more “natural” configurations. This is due to the deterioration, early in life, of some of the cells in the visual cortex. It is generally proposed that there are several different types of cells which correspond to particular types of visual stimuli. If cells are exposed to the stimuli which is their particular “forte” then they will be strengthened and if not they will degenerate. In this way the brain develops according to the demands of a specific environment.

These findings support the relativist stance. As Jovanovski states:

“...if cultural standards, impressions, and experiences can influence no less than our visual tendencies, then, indeed, we could hardly convincingly deny that those same social characteristics can and do give rise to context-identifiable ideas, interpretations, worries, phobias and obsessions.” (p. 295).

This is a powerful objection to those who posit the cross-cultural similitude of mental disorders based on the universality of neurophysiological structure. During infancy the human brain is remarkably plastic, largely because compared to other mammals it is, at

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<sup>4</sup> The important role of language in mental disorder is discussed in more detail later in the chapter.

birth, relatively underdeveloped (Kolb & Whishaw, 1996). The human infant is born comparatively premature and during the first year of life its brain along with the rest of its body grows rapidly. This growth is to some extent context dependant, meaning that it is influenced by environmental factors. And this shaping continues throughout childhood and to a lesser extent into adulthood (Weinberger, 1987).

Mukherji (1995) states:

“...while there are many “hard-wired” aspects of brain function and development, there is a vast and relatively undifferentiated network where patterns of transmission are laid down as a function of the persons learning history. Thus, the ways in which information is transmitted through the brain, and the actual form of the networks themselves are modified by learning, by the person’s experiential history...” (p. 207).

There is a complex and dynamic interaction between phylogenetic and socio-cultural factors. Although as Draguns (1995) notes, little is known of how this interaction produces psychological symptoms. While the above research may be convincing evidence for the plasticity of the nervous system, its application to cross-cultural psychology represents an argument from analogy. Visual systems differ markedly from those implicated in psychopathology and moreover, it is their normal functioning which is described here as opposed to the dysfunction of mental disorder. However, when so little is known of the neurobiological substrates of mental disorder, the possibility of cross-cultural variation needs to be acknowledged.

In response to the claims of cultural relativism, Brown (1991) presents strong opposition in his book titled ‘Human Universals’. His primary thesis is that although there is superficial variation between human beings across different societies there are more prominent similarities. He accuses anthropologists of effecting a bias toward the discovery of difference while often ignoring the blatant sameness of human cultures. In support of his stance he refers to biological, behavioural and social phenomena and offers a comprehensive list of human universals including, for example, phonemes, interpersonal relationships, child birth and law. His description of the UP (Universal People), while in some ways naive and underdeveloped is compelling and should remind relativists that while there is evidence of some degree of cross-cultural

variability in people there is nonetheless an impressive core of that which is quintessentially 'human'.

To what extent this common humanity influences, or manifests in, mental disorder is unclear. It is a question which is probably best answered empirically. If, for example, on investigation, so-called culture-bound syndromes (or at least some of them) turn out to be just that, or schizophrenia is found to be absent from some populations then the relativist view would be strengthened. If however researchers decide that culture-bound syndromes are best understood as superficially coloured variants of Western disorders then a universalist conceptualisation of mental disorder would be supported. Littlewood (1990) writes:

"Psychiatry remains balancing the two dominant academic paradigms: in that of the natural sciences, biological processes determine behaviour and experience; in that of the humanities and social sciences, human societies select out for remark, classification, and amplification certain aspects of the natural world. Going one way we have biological determination, going the other way we have social choice." (p. 311).

This debate will be drawn out in latter chapters with an examination of the relevant empirical literature.

## *SOME DIMENSIONS OF DIFFERENCE*

Those who champion a culture-relative view of mental disorder often cite general cross-cultural differences and argue that such differences must inevitably impact on abnormal as well as normal behaviour. Variables frequently referred to include the 'self,' personality, language, and more generally 'world views.' A contrast which is frequently described is that between East and West. Laungani (1992) provides a useful discussion of some of the primary differences between a typical Western belief system and an Indian one. He lists 'four core values or factors:'

1. *Materialism.....Spiritualism*
2. *Individualism.....Communalism*
3. *Freewill.....Determinism*
4. *Cognitivism.....Emotionalism* (p. 234)

Materialism is the thesis claiming the existence of a 'real' world comprised of matter. This view is the dominant ontological paradigm of Western science and as such is influential in psychiatry and general medicine. Diseases are seen as discrete physically instantiated entities (although in psychiatry the physiological correlates of disease are less clear). Materialism is also evident in the beliefs and values exhibited in the everyday lives of many Westerners. Success in life is often equated with the accumulation of material objects and many people devote themselves to this end. In contrast Indians centre their existence around the notion of spiritualism and see the external world as *maya* (illusory). Their ultimate aim - to transcend the confines of the physical world and reach a state of heightened consciousness. Central to this view is a belief in the interconnectedness of mind and body. The transient nature of the external world is related to its connection with mental phenomena. Traditional Indian methods of healing, such as yoga, reflect this view, encouraging interactionist and holistic models of illness. But accounts of mental disorder may be wholly spiritualist. It may be attributed to spirits or witchcraft and treated by a guru, shaman or mystic. As Laungani explains, such practitioners in India are afforded the same respect as trained psychiatrists.

Another important feature of Indian culture which distinguishes it from the West is communalism which is contrasted with individualism - a distinction which is central to much cross-cultural psychological research (Kleinman & Kleinman, 1991). Indians typically live with their extended family in a close-knit community. From their relationship with their family Indians gain a sense of identity and a place within the community. The status of an individual depends largely on the status of his or her family. The extended family network provides emotional and financial support - problems or difficulties are often dealt with jointly (even problems which in the West might be considered personal) - but family members are expected to conform to familial and societal norms, as in the eyes of the community deviance may be seen to affect the entire family. The pressure on individuals to conform to the expectations of their family may exacerbate mental health problems (Channabasavanna & Bhatti, 1982), however Laungani claims that overall extended family modes of living have a positive influence on mental health. He states that they, "...provide inbuilt safety measures against mental disturbances." (p.238).

Western society, on the other hand, emphasises individualism. The typical nuclear family is insular and is not necessarily part of a distinct community. Westerners generally place great value on autonomy and independence and hence problems are often handled alone. A mental disorder therefore is usually seen as an individual problem and perhaps even a weakness. The mentally ill may be judged as incompetent, for example their illness may be interpreted as an inability to handle stress. Laungani explains that in individualistic societies people are conditioned into accepting others evaluations of them. With regard to the Western materialist conception of mental disorder, which favours a bio-medical model, the ascription of blame makes little sense. This incongruence is due perhaps to the fact that lay conceptions of mental disorder are typically non-biological. Depression would not be viewed as beyond a person's control in the same way that heart disease would be.

Laungani's third dimension of difference is delineated by the concepts 'free will' and 'determinism.' As he explains, although these notions have been the subject of much discussion over many years, the question of which provides a better explanation of human behaviour is still debated. In Western thinking both views are evident. While biological and medical research programmes operate on deterministic assumptions social scientists usually evidence a belief in the notion of free will. And of course a belief in the idea of voluntary action is reflected in everyday life. There is a pervasive belief that people are able to make choices and hence that they may be held accountable for their actions. So individuals may take credit for their successes and accept responsibility for their failures. If therefore a mental disorder is viewed as a failing, it may be a blameworthy one.

In contrast Indians generally subscribe to a deterministic construal of life. This is based on the Buddhist and Hindu *law of karma* which rewards and punishes past deeds (of present and past lives). In this sense current events are seen as the consequence of past events and therefore as predetermined (although of course one may influence ones future by changing ones present). As Laungani states, this philosophy of the ups and downs of existence may have the effect of taking away 'the sting and stigma from suffering.' (p.240). Misfortune is destined and therefore outside a person's immediate control. In this regard people may be more accepting of ill health however there is an associated risk of indolence. Indians who believe in karmic laws may feel ineffectual

and rather than take action, against disease for example, they may resign themselves to the inevitability of whatever is coming to them.

Fourthly and lastly Laungani discusses the distinction between cognitivism and emotionalism which he says is exhibited by, ‘...the way in which British and Indians construe their social worlds.’ (p.240). He claims, using the suggestion of Pande (1968), ‘that Indian society is *relationship centred* and British society *work-and-activity-centred*.’ (p.240). In the former there is evidently a focus on rationality and control wherein the unfettered expression of emotion is discouraged. And relationships in this context revolve often around commonalities of occupation, because it is occupation that usually denotes ones status. In contrast a relationship-centred social structure is more likely to revolve around and value emotionality. The open expression of feelings - positive and negative - is integral to life in an extended family and is not seen as weakness of character. And nor is such candour disturbing to those who receive it. Outbursts, even of anger, are often treated lightly and seen simply as a natural means of releasing emotion.

Relatedly Varma (1986) contrasts the ‘cognitive styles’ of India and the West. He describes the predominant Indian cognitive style as ‘synthetic-gestalt’ and the prototypical Western one as analytic. The former is said to view things holistically and to note the relationships between them. Accordingly interactions between objects and phenomena are seen as central and explanations aim for an understanding of the totality of interrelated events. The analytic mind on the other hand attempts to explain by breaking objects or phenomena into their constituent parts and searching for ever smaller (or lower) elements. In this way explanation may involve the analysis of isolated constituents. Varma suggests that the differences in cognitive styles may be related to the dependency/independency continuum. He states that a synthetic style may be more compatible with an interdependent existence and an analytic one with a more autonomous way of life.

On the subject of the Western focus on work, which was briefly mentioned earlier Varma (1986) discusses the contrasting Indian approach to performing ones job. This is summed up by the words ‘chalta hai’ (meaning ‘will do’) which expresses the apparently typical Indian attitude to work, which is to basically do as little as possible

without endangering ones position. On the other hand Westerners often demonstrate a degree of obsessionality or compulsivity in the work place, says Varma, devoting themselves to their jobs and pushing themselves to the edge of their ability. If his analysis of the Indian work ethic (if one can call it that) seems derogatory it is not intended to be so. In fact he speculates that perhaps in the past Indians tried the committed and compulsive approach to work and found it '...to be inadequate to answer the basic issues of human existence.' (p. 25).

While these representations of various aspects of Eastern and Western cultures are interesting and at times insightful they are of course unreservedly simplistic. They involve the ascription of sweeping generalisations which explain the behaviour of millions of people with a single label. However whether or not such generalisations are accurate they are nonetheless representative of common conceptions of the primary differences between Eastern and Western ways of life. It is variables such as these which are often claimed to affect mental disorders across cultures. Undoubtedly there *are* differences between cultures in many aspects of socialisation however the depth of these differences and their significance with regard to the manifestation of mental disorder is uncertain.

## *CULTURE AND MENTAL DISORDER: TWO CASES OF NEURASTHENIA*

The following case study was recorded by Arthur Kleinman an eminent psychiatrist who has worked extensively with clients of non-Western backgrounds (particularly Chinese). It was first reported in 1986.

Kleinman and Kleinman (1991) relate the case of Huang Zheni, a man in his late twenties, residing in rural China. He reports that he feels despondent, hopeless and desperate and that he does not like himself. He also says that he experiences chronic headaches and dizziness and he attributes all of these symptoms to childhood trauma during the Cultural Revolution. He recounts two distinct incidents. In one he was eight years old. He went fishing with some classmates when he should have been at school. Subsequently the boys arrived at class much later than usual. As punishment they were



locked in a small mud room, from which they escaped by digging a hole in the wall. Huang's two friends were caught by the teacher but Huang escaped. The following day on returning to school he was ordered by the teacher to do menial work instead of study, but Huang refused. As a result he was severely criticised by his teacher, in front of other teachers. After this incident Huang stated "my liver became small and I became frightened, cowardly." Since that time he said that he has felt 'paralysed' whenever he has had to assert himself before adults.

The other event took place when Huang was twelve. While walking in the schoolyard one day during winter vacation Huang found a note, tacked to a wall, which read "Throw down chairman Mao." Unsure what to do about the anti-Mao message he sought advice from a close friend who told him to inform their commune leaders. After doing this the leaders called the police. The police asked Huang to tell them who had written the poster and when he was unable to tell them they accused him. He was told that if he did not confess he would not be allowed to go home. During this time he was kept in a small room on the school grounds and was not allowed to urinate even though he urgently needed to do so. He told the policemen again that he had found the slogan and did not know who had written it. Finally, late at night Huang was allowed to return home. His mother was distraught over his absence so he explained what had happened.

The following morning the policemen arrived at Huang's home and took him to the public security building. There he was told that he would not be allowed to leave until he had admitted responsibility for the crime, so he signed a confession. Later when he arrived home he told his mother that he had written the slogan, as he believed that if he was honest with her there would be further trouble. His mother responded by crying and cursing him. She stated that she would not have wanted him if she had known he would turn out this way. Huang recalled that at this point he broke down in tears and was unable to tell her the truth. He said "I felt like a coward. I couldn't tell her."

After confessing to the crime, Huang was forced to march through the town wearing a dunce cap and a sign, written himself, which displayed a self-critical message. He was surrounded by local people who cursed him, spat on him and threw stones and soil at him. The next day he was sent to an adult work place where he was expected to do hard labour. The work was exhausting and often while he worked local children shouted

insults at him. Huang remembered that during periods of fierce criticism he felt numb and even 'paralysed.' He often wanted to declare his innocence but felt unable to do so. He reasoned that he would not be believed. Eventually after a full year of heavy labour, his work mates, who were impressed with his diligence, appealed to the local authorities to allow Huang to return to school. This was granted so Huang then shifted to another province where he was not known and continued his schooling. He later joined the communist party.

Huang never told his mother the true account of what had happened. He says that he wanted to when she was dying but felt afraid and thought also that '...it would not do any good.' Hence Huang's mother died without knowing that her son was in fact innocent. Huang reports that this fact is a constant source of shame and self-loathing. Looking back at these events he feels utterly dejected. He expresses anger, toward his friend who would not admit to the authorities that Huang had only found the poster and had not written it, and toward the policemen who interrogated him. He says that he experiences an intense sense of injustice which he associates with a burning sensation in his head, dizziness and fatigue. He also feels afraid that someone in the Communist party will find out about his history and have him expelled.

Huang states that he does not expect to recover from this event. "It has affected my character. I am withdrawn; I don't like to be too friendly with others. I am a coward. I cannot trust others." He says that he would like to write about his experiences in a way that would illustrate the "losses and defeat" that have befallen his generation, however he has no ability or training for this sort of task. And he says that, anyway, whenever he attempts to write anything down he is overwhelmed by feelings of weariness and dizziness, and by an awareness of his own inability. He often refers to this inability as 'paralysis,' not physical, but mental; a profound powerlessness which prevents him from acting. He also reports feeling trapped, and continually fearful that others will learn about his past.

He identifies his past experiences and present discontent with others who suffered during the Cultural Revolution. In this way he does not see his own suffering as an isolated case but rather as one of many young people who experienced trauma of one sort or another. However as noted by Kleinman, Huang's story is unusual in that it does

not revolve around the loss of loved ones. Rather Huang lost his innocence, his youth, his self-esteem, his confidence and his hope for the future. Of course many of his compatriots would have experienced trauma without consequently developing a disorder. Huang was probably vulnerable and his crisis therefore particularly injurious.

According to Kleinman, Huang's self-described symptomatology is best understood in terms of Chinese language and culture. One of Huang's primary symptoms is dizziness, in Chinese *tou yun*. This is often construed in Chinese medicine as the result of an imbalance between the mental and physical constituents of the body, and the social world. This imbalance is believed to arise, through changes in *qi* (vital energy) - its amount and circulation may vary - and out of past experiences. Equilibrium, both physical and emotional, is disturbed causing various unpleasant physical and psychological symptoms. Huang's other main symptom is weakness which seems to have both a mental and physical dimension.

The psychosomatic nature of Huang's symptom report reflects Chinese conceptions of distress. Negative experiences which might in the West be seen to have psychological consequences, may in China be seen to manifest physically. The expression of responses to political oppression through such symptom patterns is widely accepted. In China this configuration of pathology is typically diagnosed as 'neurasthenia'. This disorder was first referred to by an American neurologist last century and disappeared from the American Psychiatric Association's classification less than 20 years ago (Starcevic, 1991). Today it is a diagnosis most commonly given in China, Korea and Japan. Neurasthenia is characterised by fatigue, diminished enjoyment and various bodily complaints, such as headache.

Kleinman's diagnosis of Huang is 'depression' - there were other clinical features not described here - however he acknowledges that a Chinese physician would probably give a diagnosis of 'neurasthenia.' With regard to another similar case study (Kleinman, 1988) he states:

"For the anthropologist, the problem seems more that of demoralisation as a serious life distress due to obvious social sources than depression as a psychiatric disease. From the anthropological vantage point, demoralisation might also be conceived as part of the illness experience associated with

disease, neurasthenia or depression. Here *illness* refers to the patient's perception, experience, expression, and pattern of coping with symptoms, while *disease* refers to the way practitioners recast illness in terms of their theoretical models of pathology...Thus a psychiatric diagnosis is an interpretation of a person's experience." (p. 7).

Kleinman's distinction between 'illness' and 'disease' was introduced in the previous chapter. On the one hand there is the actual illness experience and on the other there is the way that this experience is interpreted by the physician, namely in terms of disease categories. Kleinman also makes the point that the problem must be viewed in light of the personal and social context in which it has arisen and to which, according to the patient, it is inextricably tied. In the case of Huang Zhenyi, his feelings of shame and fear and his profound anger at the injustice that befell him are only fully understood with reference to the socio-political environment in which they arose. It was this environment which caused the events and it was this environment which mediated their particular consequences, in the form of psychopathology, for Huang. Huang's illness experience was shaped by cultural conceptions of suffering.

Obviously political oppression of this nature is not limited to China. It is common world-wide and probably with equally deleterious psychological consequences. Huang's story resonates with other tales of oppression and may be easily understood even by someone who knows little of Chinese history. However while it may be interpreted as a tale of miscellaneous human suffering, Kleinman sees Huang as very much a cultural product with a history unique to a particular place and time. His illness stems from this and is best understood in this regard. This does not mean that he should not receive a diagnosis, but simply that any clinical account of his morbidity should acknowledge this. Moreover his symptomatology is culturally framed, expressing a specific 'folk' conceptualisation of disease. And this conceptualisation is corroborated by Chinese physicians.

This example raises questions about the nature of mental disorder. Is Huang depressed or does he suffer from neurasthenia? Do his symptoms actually differ from those of a person who is diagnosed with depression? Or is it only his interpretation of them which is different? Should a mental disorder be understood in the context in which it occurs or is it something which is universal? Why is it that two physicians may give a person two

different diagnoses? Is the same-culture diagnosis necessarily more valid? These questions relate both to theoretical and clinical matters. An obvious and important goal is successful treatment for the patient and another is to establish some degree of conceptual understanding which is generalisable. In other words one can use cross-cultural examples such as these to learn something about the nature of mental disorder.

The diagnosis of neurasthenia still appears in the ICD 9 - where it is described as a neurotic disorder - although it is a diagnosis rarely used now in Western Europe (Starcevic, 1991). Shorter (1995) includes it in a list of psychosomatic complaints which he claims are subject to a substantial degree of 'cultural moulding.' He explains how these sorts of complaints which may also be referred to as 'conversion reaction,' 'nondisease' or 'persistent somatisation,' have appeared in various forms over the years. During the 1600s numerous cases of pseudoepilepsy were documented. Two centuries later hysterical paralysis became rather prevalent. This disorder, which typically affected young women, was indicated by partial or complete paralysis of one or both lower limbs.

During the 1930s a bacteriologist claimed that cases of neurasthenia were actually chronic brucellosis. Following reports of this 'new' disease by the media, many people presented themselves to physicians with the belief that this was the label that best fitted their symptoms. At around the same time the condition of 'hypoglycemia' was first described. Symptoms of this disorder were typically psychological in nature yet they were attributed to a deficiency of glucose in the blood stream. Looking back, it is now clear that there was no evidence for either of these conditions, even though they were 'discovered' by medical experts. The latest conceptualisation of this type of psychosomatic illness entity is chronic fatigue syndrome (CFS). Initially, it was claimed that this disorder was caused by the Epstein-Barr virus, a virus which was found in those with chronic fatigue. However, later studies revealed that this virus evidenced with equal frequency in those without such symptoms. Hence, once again, hopes for an organic basis for amorphous psychosomatic symptoms were unfulfilled.

Yager and Young (1974) point out that many people desire a diagnosis which has a clear organic etiology as it means that they can avoid the stigma of a psychological illness. Metabolic conditions are often believed to be more respectable. This may be

why Neurasthenia is a more common diagnosis in China and Japan. Munakata (1989) reports the case of a Japanese pilot who crash landed killing some and injuring many of his passengers in 1982. For several years prior to the crash, the pilot had been receiving treatment for a 'psychosomatic disorder' and 'malfunction of the autonomic nervous system.' He had time off work to recover and was subsequently considered fit to return to work. It was later discovered that the pilot had been prescribed a particular psychotropic medication which is typically given for schizophrenia. And according to the final air accident report, the cause of the crash was the pilot's sudden response to an auditory hallucination, wherein he changed the plane's trajectory, away from the normal landing path.

The pilot's sister confirmed that he had been acting strangely, reporting frequent delusions and hallucinations. It appeared that the pilot had been given a disguised diagnosis so that he could avoid the social stigma associated with a mental disorder. Apparently the pilot's elder sister had died in a mental hospital and his family had attempted to conceal her existence. This may seem extreme, however it is not if one considers the importance of family connections in Japan. A diagnosis of a mental disorder is something which would have ramifications for all members of a particular family. For young women it may mean diminished marital prospects. Japanese physicians are acutely aware of such consequences and often attempt to protect people by giving disguised diagnoses, such as neurasthenia. In the case of the pilot this false diagnosis had serious consequences.

This example demonstrates the social dimension of diagnosis. In Japan as in some other countries, the label neurasthenia legitimises psychological symptoms by giving them an organic explanation. Today, in the West, similar symptom patterns would probably be diagnosed as CFS. Historically, such labels and conceptions change according to prevailing medical theories and media interest. According to Shorter (1995) the increase in somatic illness in the West correlates with less tolerance of depression which reflects societies' general responses to 'madness.' Ware and Kleinman (1992) provide an interesting analysis of the social embeddedness of neurasthenia and CFS. They state that:

...health and suffering, like other existential states, are patterned by culture *realised* as local worlds of experience. The process is one in which events in the local world - moral, political, economic - mediate the effects of large-scale social forces in ways that are reflected in cognitive, affective, and physiological changes. The result is the manifestation, exacerbation, and/or alleviation of symptoms. The experience of illness in turn structures and shapes the local world by serving as a vehicle for change in the character of social life for both the sufferer and others with whom he or she regularly interacts. (p. 547).

Suggested here is a dynamic interplay between illness and society wherein each may influence the other. Not only is society seen to shape illness, but illness is also seen to shape society. In the case of Huang, one can argue that the way he experienced his disorder was shaped by his culture and that his culture is in turn shaped by the responses to illness of those like Huang. The relationship of culture to illness is also seen in the case of the Japanese pilot. In many societies mental illness is stigmatised (Fabrega, 1991), hence a particular diagnosis may have serious consequences for individuals and their families. Physicians therefore, may respond to social forces, as well as physiological and behavioural ones when forming a diagnosis.

These examples reveal some of the ways in which culture may be seen to interact with the manifestation and diagnosis of mental disorder. This complex interaction is central to many of the issues and difficulties of cross-cultural psychology.

## *ISSUES AND DIFFICULTIES OF CROSS-CULTURAL PSYCHOLOGY*

Nilchaikovit, Hill & Holland (1993) report the case of a 24 year old Korean woman who has been diagnosed with leukaemia and referred for psychiatric assessment. The assessment was done jointly by one Asian and one American physician. Following the initial evaluation the physicians had developed quite different views of the patient and hence different treatment plans. The American physician reasoned that the patient was suffering from a lack of independence and control, due to her parents' overinvolvement, hence his recommended intervention involved assisting the woman to distance herself from the family and establish some space and autonomy. In contrast, the Asian physician believed that the patient wanted to maintain the involvement of her

family, and saw her symptoms of passivity and regression as an expression of a cultural norm, as opposed to a sign of pathology.

The authors use this case to illustrate the importance of understanding the cultural background of patients. Although their paper centres on purely physical disorders they make some pertinent points. Conceptions of self and conceptions of the relationships between self and others may affect illness attributions. And responses to illness may vary according to one's particular existential views. Such views are often mediated by religion and cultural heritage. According to Nilchaikovit and colleagues: "In order to understand cultural influences on human behaviour, it is crucial to understand the varying ways in which the concept of self and self-other relationships are experienced, defined, and used among cultures of the world" (p. 49). This is one of the primary challenges of cross-cultural psychology and has implications for both clinical and research practices. This section provides a brief discussion of some of these implications.

One of the major barriers to cross-cultural understanding in psychology and psychiatry is differences in language. Many societies today are multi-racial and multi-lingual so it is not uncommon for health professionals to interview clients who have a different first language. Sometimes such clients are emigrants who may speak the language of their new locality, but less proficiently than their native tongue. Westermeyer (1987) states: "The patient may have limited vocabulary, grammar, syntax, and use of idiom in the second language." (p. 161). And as Westermeyer notes, amidst the symptoms of mental disorder the ability to communicate in a second language is often impaired. When using a second language a patient's psychosis may be exaggerated and the physician may overestimate the severity of pathology. Others may express greater distress in their first language due to better fluency in this medium.

Sometimes psychologists and psychiatrists must carry out interviews with the help of translators. These may be people especially trained for this sort of task or otherwise family members or friends of the patient. Marcos (1976) says that difficulties can arise if a family member or friend takes on the role of translator. They may attempt to avoid asking questions about topics such as sex, suicidal ideation and other typically personal matters. And there is a tendency for lay interpreters to translate selectively according to



their own perceptions of the situation. They might also disrupt the interview by expressing their own analyses and related suggestions. For these reasons, properly trained translators are often preferred. With some psychiatric knowledge and intimate understanding of the client's language and culture they are more likely to facilitate the interview process. However professional translators are not always available. In lesser developed countries where they are often most needed there is a palpable lack of resources and translators are unlikely to be considered a priority. Commenting on medical resources in America, Westermeyer states: "The recent focus on biological psychiatry has resulted in virtual abandonment of socio-cultural research funding." (p. 164).

Westermeyer's claim has been echoed elsewhere. Mental health treatment programmes in many developing countries are unable to meet even the most basic of demands so there is little time or money for socio-cultural investigation. In India the proportion of psychiatrists to the general population is slightly over one per million and conservatively it has been estimated that at least 4000 per million would have a mental disorder (Laungani, 1992). Obviously Indians would seek other forms of treatment besides that offered by psychiatry but this may be due to the scarcity of psychiatrists and the cost of consulting one rather than an inherent preference for alternatives. As Wig (1989) explains, in developing countries psychiatry is typically a 'minor clinical speciality' which revolves around the institutional care of those with chronic mental illness. Psychiatric care is available to others only through the private sector which means that for many it is unaffordable.

The limitations of psychiatric services in these contexts exacerbate the problems of cross-cultural understanding. Because psychiatric training in many of these countries is inadequate, professionals may be trained elsewhere, in contexts quite different from that in which they will ultimately work. Often developing countries must rely on Western trained clinicians and researchers who are unfamiliar with local language and culture. According to Kleinman (1987), vernacular difference is typically viewed by psychiatrists as an impediment to understanding, and translation, as an annoying technical difficulty. For the anthropologist however, "...translation...is the very essence of ethnographic research" (p. 451). Anthropologists attempt to gain an understanding of language with reference to the broader cultural context. For them the translation of

findings into terms which are suitable for cross-cultural comparison comes only after a period of cultural immersion during which the investigator attempts to understand the social environment from the inside out (as opposed to the reverse). But, as Kleinman explains, translation is often the first step in a psychiatrist's investigation, as at the outset diagnostic assessment tools are translated into local idioms.

The use of Western-devised and Western-oriented diagnostic tools in non-Western settings has been the focus of much debate over the years. Kleinman claims that many such assessment instruments are not readily translatable. He states, for example, that some North American diagnostic tools measure dysphoria with the terms 'feeling blue' or feeling down' which are meaningless when translated literally into other languages. The most commonly used Western diagnostic instrument for the measurement of depression is the Beck Depression Inventory (BDI) which has also been used extensively in non-Western settings. The BDI has been translated into several languages and used in a number of ethnic groups with reasonable success. For instance studies carried out in Chinese, French-Canadian and Swedish populations using appropriately modified versions show good reliability (Naughton & Wiklund, 1993).

Zheng and Lin (1991) compared the use of the Chinese version of the BDI (CBDI) with the Chinese Depression Inventory (CDI) and found the latter to have superior reliability and validity. The reason for this, they explain, is that items in the CDI were derived from an analysis of the ways in which depressed Chinese express emotional and somatic experiences; ways that are culturally distinct and not entirely captured by the CBDI. They ascribe the disparity between the two scales to differences in the verbal expression between North American and Chinese cultures and conclude that "...there is an obvious limitation in the application of Western self-report scales to non-Western populations even if they are accurately translated in the semantic sense." (p. 531). (Or perhaps *because* they are). One of the primary reasons for devising standardised diagnostic instruments which may be used cross-culturally, is the ease with which results may be compared. It is obviously difficult to compare results from different psychometric tests. However such comparison is useless if results do not provide an accurate representation of people's mental states.

Even if one decides that Western-developed diagnostic schedules such as the BDI can be used reliably across cultures, there are other reasons why their use may still be problematic. In many developing countries there is wide-spread illiteracy so questionnaires requiring reading and writing may be impossible. Moreover many people may be unfamiliar with the notion of a psychological test and may have difficulty carrying out the necessary self-reflection and self-assessment (Lonner, 1990). What is being suggested, is not that these people have limited self-awareness, but rather that they have not previously measured their thoughts, feelings and behaviours in this way. Rating scales require a particular, quantitative and linear, form of self-evaluation which may be foreign to some people. Hence they may question the value of such tests and not take them seriously.

The problem of patient cynicism manifests more widely. A Western clinician and/or researcher in a lesser developed country, such as India, bringing with him or her foreign ideas and techniques, may not be warmly received. The Western conception of mental disorder does not 'fit' with traditional Indian approaches to its understanding and therefore patients might feel that they are being imposed on. This raises ethical questions: What level of explanation is considered satisfactory before a particular treatment can proceed? Is it acceptable for a Western physician to treat a patient in this context? Note that in the West, people who are 'committed' are often diagnosed and treated without being told either their diagnosis or their treatment plan, even if they are considered able to understand it.

Of course if mental disorders are seen as primarily the result of neurobiological dysfunction then questions of this nature might seem trivial. According to some theorists, pharmacological treatment for schizophrenia would be expected to be equally effective in all populations. But even if it is effective, physicians in these contexts have a responsibility to explain their conceptions and procedures to patients, and gain consent for interventions. Westermeyer (1987) notes that it is important for clinicians to realise that they too have belief systems which are intimately connected with their own culture. This awareness aids the appreciation of cultural difference. However even if a psychiatrist or psychologist understands the culture of their client, accurate assessment is difficult without culture-sensitive instruments.

Channabasavanna, Raguram, Mitchell, Parvathavardhini & Thriveni (1993) report a study involving the adaptation of the Explanatory Model Interview Catalogue (EMIC) for use in South India. The EMIC, a relatively new assessment tool, arose largely out of Kleinman's 'explanatory model theory.' It was Kleinman's aim to devise a method for cross-cultural understanding which could acknowledge the personal and cultural significance of mental illness yet still be intelligible and comparable to Western psychiatry. "The EMIC makes operational a cultural model of illness having four components: 1) patterns of distress, 2) perceived causes, 3) preferences for help-seeking and treatment, and 4) general illness beliefs." (Channabasavanna, et al., p. 2). This approach allows the physician to create a comprehensive culture-relevant illness picture which can then be understood in trans-cultural terms. The main advantage of the EMIC is that it does not involve the imposition of Western conceptions of illness on diverse cultures. Although of course ultimately there is a need for cross-cultural comparison, with the EMIC this can be done more accurately, because it is sensitive to, and even embracing of, cultural variation. In response to their findings, Channabasavanna et al. conclude that the EMIC (which was for their study translated into Kannada) is a useful and reliable instrument in cultural research.

This sort of innovation in research techniques paves the way to more accurate cross-cultural investigation. There is an increasing awareness that there *is* a social dimension to mental disorder and that it is therefore necessary to develop clinical practices which are responsive to this fact. However radical relativists are likely to question the efficacy of such approaches, because they still inevitably use the Western approach as a touchstone of normality and abnormality. For instance there is an implicit assumption that the 'basic emotions' as defined in Western language and culture are universal. So emotional experiences as delineated by, say, a Chinese person, will be interpreted according to this conceptualisation of the so-called basic emotions. As mentioned earlier, linguists such as Whorf (1950), have long argued against this analysis, suggesting instead that the basic emotions are actually artefacts of the English language.

Wierzbicka (1992) has written extensively on this proposition, with detailed analyses of emotion concepts in several languages. She demonstrates that in some languages, concepts such as *happiness*, *sadness*, and *anger* are not represented. For example the

Ifaluk language of Micronesia has no word that corresponds directly with *anger*. The closest word in meaning to the English *anger* is *song* which means something like 'justified anger.' But it also refers to a milder, less aggressive, emotional state than that inferred by the word *anger*. The behaviours which characterise *song*, such as scolding, sulking and food refusal are directed at the individual who has apparently misbehaved or offended. An elder is typically *song* at a younger person, or a person of lower status. Parents are often *song* at their children in order to express their disapproval. As reported by Wierzbicka, Lutz (1987) observed that Ifaluk culture actively encourages non-violent behaviour and values it more highly than it appears to be valued in most Western societies. Wierzbicka writes: "The fact that the Ifaluk language has no word corresponding to the English word *anger* and that the closest Ifaluk counterpart of this concept is much "softer" and closer to *admonition*, seems to constitute a lexical confirmation of this difference between the two cultures" (p. 306).

According to Wierzbicka the difference between *anger* and *song* represents deep culture-bound differences in the experience of emotion. With reference to this and numerous other examples Wierzbicka argues that the 'basic' emotions as delineated by the English language do not designate lexical universals. Rather they express a particular conception of emotion, dividing the experience of it according to that conception. In response to this claim, some theorists argue that although there are subtle differences between languages in the understanding and description of emotion, that there are underlying similarities which demonstrate the existence of core emotions. For instance *anger* and *song* may be seen as elaborations of a basic emotion which has something in common with both concepts.

As Wierzbicka points out however, this view is problematic in that the core emotion remains elusive and indefinable. If the basic emotion may be expressed differently in different cultures, what is it that signifies the manifestation of this emotion? It will not be signified by language, nor by behaviour unless some similarities are found within these. She states:

“The advocates of “basic emotions”... should be particularly interested in finding some universal points of reference in terms of which their hypothetical basic emotions could be identified; for without such points of reference their claims can be seen as either ethnocentric or less than truly meaningful.” (p. 297).

Wierzbicka does not doubt that trans-cultural points of reference can be found but she proposes that such universals are likely to be more basic than complex concepts such as sadness and anger. She suggests that they may be captured with terms such as *want*, *think*, *good* and *bad*.

The relevance of this discussion is obvious. Psychology, like most sciences, uses English as its principle linguistic medium. Hence much cross-cultural research revolves around English terminology. The tools of diagnosis and research typically use English concepts. This means that from the outset there is an ethnocentric element to be overcome. If anger is not something experienced by an Ifaluk person, would it be reasonable to ascribe the label of anger if that is the closest label available in one's own language? The question of the universality of emotion has deeper significance. If emotions differ across cultures then perhaps abnormal emotion also differs. If the ways that emotions are understood by, and manifested in, people are to some extent culture-relative then the ways that the malfunction of emotions are understood and manifested may be equally culture-driven.

The position of Wierzbicka and others is controversial but none-the-less coherent and compelling. The question of the relationship of language to the experience of emotion is interesting and particularly relevant to the discussion of mental disorders across cultures. Many theories of emotion stress its connection with cognition (Strongman, 1986). If one assumes that language is a form of cognition then it is reasonable to suggest that language is linked with emotion. This is perhaps a vague assertion but it is nevertheless an important one. Language may not only shape the interpretation of emotional experience but also the experience itself (which, anyway, is probably linked to the interpretation of it).

Following from this is the argument that abnormal or maladaptive emotion will be expressed or ‘channelled’ by way of the language and customs with which one is

familiar. In this case a person will be depressed only if he or she understands the concept of depression; because the concept 'depression' is part of the experience. In labelling ones own experience one is thereby changing the quality of that experience. The interpretation both personal and social, feedback into the individual's response. To some extent it is a matter of noticing what one is alerted to and what one is expecting. If cognition is understood to affect emotion then one must accept perhaps that cognition may have some control over emotion, but exactly how this control might manifest is unclear. In the case of pathological sadness, it could perhaps mean the difference between depression in the West and neurasthenia in China.

While there is more to mental disorder than abnormal emotion, the relativist argument presented by linguists such as Wierzbicka has implications for cross-cultural psychology. Most importantly clinicians and researchers alike, must acknowledge the cultural milieu of their language, beliefs and diagnostic tools. Cultural psychology based on ethnocentrism undermines the epistemological and metaphysical approaches of other cultures which may have much to offer Western thought. Moreover success in clinical contexts will likely depend on the acknowledgement and understanding of other world views. This may be difficult for the psychiatrist or clinical psychologist who lacks specialised training on cross-cultural issues.

## *SUMMARY*

As evidenced herein, the field of cross-cultural psychology incorporates a vast and diverse array of phenomena. It is characterised by a number of important issues and debates which remain unresolved. The primary goal of this chapter was to describe these and their various arguments and introduce some of the relevant literature. As discussed, the impact of culture on mental disorder is multifarious and complex, involving variables such as language, politics, and religion. Consequently the use of Western diagnostic systems in cross-cultural contexts is problematical. A Western clinician may not recognise the socio-political context of disorder in which the disorder is inextricably embedded. Or the diagnostic instruments which he or she is using may be inappropriate. As mentioned though, some culturally sensitive instruments have been developed and used with some success.

The following chapter examines the cross-cultural application of the DSM-IV with a focus on the recent cultural additions.



## CHAPTER 5

# *THE CROSS-CULTURAL APPLICATION OF THE DSM-IV*

The latest edition of the DSM displays a significant move towards cross-cultural understanding. It is for this reason that the investigation herein of the cultural dimension of psychiatric nosology focuses solely on the use of this diagnostic manual. The ICD-10 while in many ways the equivalent of the DSM-IV lacks the cultural sensitivity. With reference to the ICD-10, Alarcon (1995) states: "The attempt to obliterate the cultural component is almost blatant." (p. 458). Like earlier versions, the ICD-10 utilises a rigid and universalistic approach to the understanding of psychopathology. The extent to which the DSM-IV is superior in this regard - therefore the extent to which it is cross-culturally effectual - is the subject of this chapter.

Following a brief description of the history of the DSM series, is a discussion of the development of the cultural components of the DSM-IV. The efficacy of these modifications has been the subject of widespread debate. While some view them as giant leaps forward, others see them as small steps albeit in the right direction. One question which clearly deserves attention is whether a diagnostic manual of mental disorders should aim for universal usage. Perhaps such an aim detracts from the more important goal of understanding the tremendous variation in the manifestation and interpretation of mental disorders in different socio-cultural environments. The answer to this depends in part on the cross-cultural presentation of disorders such as depression and schizophrenia which are pivotal to Western conceptions of psychopathology, and on the prevalence of culture-specific disorders which can not be explained with the application of Western diagnostic categories.

Following an evaluation of the cross-cultural components of the DSM-IV is a look at some of the culture-bound syndromes which are listed in the manual. This is followed by a discussion of the cross-cultural manifestation of depression.

### *THE DEVELOPMENT OF THE DSM-IV*

The inaugural edition of the Diagnostic and Statistical Manual of Mental Disorders was published in 1952. It listed 106 diagnostic categories and was influenced greatly by the ideas of Adolf Meyer (Skodol Wilson & Skodol, 1994). Meyer was perhaps one of the first theorists in the field to propose a multi-dimensional model of mental disorder, acknowledging the influence of psychological, social and biological variables. The DSM I was also based on Freudian theory (Alarcon, 1995); its diagnostic criteria typically subjective and theory laden, suggesting links between unconscious reactions and nebulous stressors. These two rather divergent theoretical influences rendered a diagnostic manual of little practical use. It lacked operational definitions and hence relied heavily on therapist interpretation.

The DSM-II, published in 1968, was undoubtedly an improvement; it eliminated much of the psychoanalytic theory of the earlier edition and adopted a more descriptive and objective methodology (Alarcon, 1995). However it was not particularly consequential in psychiatric circles. It was not until the appearance of the DSM-III that the APA became a significant force in psychiatric nosology. Published in 1980, the third DSM extended the use of descriptive diagnostic criteria with the aim of multi-theoretical compatibility. It was broadly based on a biopsychosocial model of psychopathology, reflecting developments in psychopharmacology and growth in cultural understanding (Alarcon, 1995). Yet its aim was to be atheoretical - to describe psychopathology without reference to any particular theory. However as many theorists have pointed out (e.g. Nikelly, 1992; Poland, Eckardt & Spalding, 1996) it was not atheoretical. The process of classification necessarily involves the application of theory. For instance the DSM-III introduced a multiaxial system dividing mental disorders into several general kinds. The development of this framework would (at the very least) have involved the ascription of theories of the similarities between particular disorders.

Although the DSM-III was purported to have displayed better reliability than its predecessors (Skodol Wilson & Skodol, 1994), it met with some criticism, especially with regard to the cross-cultural applicability of the manual (Alarcon, 1995). Many of the mental disorders included in the manual were not found outside the West. As noted by Alarcon, 80% of the total human population exist in non-Western cultures, hence it could not be considered a truly international classification system if it was based solely on Western conceptions of disease. In response to such criticisms, revisions to the DSM-III in 1987 included an acknowledgement of the limitations of the manual in diverse cultural settings and a recommendation that clinicians respond with sensitivity to differences in language, values and behaviour. However for those expecting a major move towards the embodiment of cultural factors this modification was seen as nothing more than a token gesture. Clearly the DSM-III-R expressed "...Western or more appropriately American cultural commitments." (Alarcon, 1995, p. 453).

The Task Force involved in the development of the DSM-IV sought to address this issue with the aim of enhancing its efficacy, in the multi-ethnic environment of the U.S.A., and in diverse international settings (Skodol Wilson & Skodol 1994). As noted by Lewis-Fernandez and Kleinman (1995) the use of the DSM (in its many forms) has increased over the years to the point where it has surpassed the use of the ICD-10 in some countries. It is now widely used in Japan and in the U.K. It was the aim of those instrumental in the development of the fourth DSM, that cultural issues be rigorously addressed. Hence a committee was set up to establish the inadequacies of the DSM-III-R in this area and propose ways of improving the cultural validity of the forthcoming edition.

This investigation culminated in a number of changes. Basically the DSM-IV attends to cultural factors in three ways. Firstly, it includes in the text, a discussion of the cross-cultural differences in the presentations of some disorders. Secondly, it provides in an Appendix a list of culture-bound syndromes. And thirdly, it outlines a cultural formulation for the assessment of cultural factors, which may be used in conjunction with each of the axes of the DSM-IV. The cultural formulation uses the following five category headings:

- Cultural identity of the individual.
- Cultural explanations of the individual's illness.
- Cultural factors related to psychosocial environment and levels of functioning.
- Cultural elements of the relationship between the individual and the clinician.
- Overall cultural assessment for diagnosis and care.

(DSM-IV p. 844)

The cultural formulation, then, is a substantial and complex addition to the diagnostic procedure. It allows, within diagnosis, the embodiment of the many rich and diverse aspects of culture and acknowledges their multi-dimensional impact on the individual and his or her psychopathology. Mezzich (1995) describes some of the potential benefits of the use of the cultural formulation in clinical assessment. He states, firstly, that one of the primary advantages is the greater capacity for understanding the patient and his or her situation. After recognising the culture with which the client identifies, the clinician should gain an understanding of the client's own-culture illness explanation and of the ways in which his or her culture might impact on the illness.

As noted by Mezzich another important advantage of the cultural formulation is the potential for data collection. Traditional diagnostic approaches focus on prototypical symptom patterns to the exclusion of other potentially relevant variables. They provide no systematic way of recording or considering culture-specific factors. This means that a large body of information which may enhance understanding of cross-cultural issues is lost. The cultural formulation encourages the inclusion of cultural data, not only for the benefit of the client but also for the purpose of expanding and enriching the knowledge of the impact of culture on psychopathology. Perhaps one of the most important aspects of this practice is the inclusion of individual perceptions of meaning. Fundamental is how the patient construes his or her illness because such self-examination and self-diagnosis is an important indicator of cultural conceptions of illness.

The third and last benefit of the cultural formulation, suggested by Mezzich, is the general enhancement of the clinical process through a better client-clinician relationship. If the client feels that his or her beliefs, values, and practices are

understood and respected by the clinician, then there is increased likelihood that good rapport will be established and that the client will trust the clinician and his or her clinical procedures. A psychiatric assessment is, at the best of times, a daunting affair. This apprehension may be magnified by cultural differences between the client and clinician, especially in environments where there is tension between ethnic groups. The cultural formulation offers a way of fostering cross-cultural understanding so as to facilitate communication and establish a culture-sensitive approach to diagnosis and treatment. The application of a diagnostic label may be experienced as intimidating even when it is a label with which one is reasonably familiar. It is likely to be experienced as even more intimidating if it is seen as representative of an entirely foreign system of illness interpretation.

Hence it is important for the psychologist or psychiatrist to not only show an appreciation of the client's cultural background, but to also acknowledge the cultural relativity of his/her own diagnostic and treatment methods. An aspect of this involves offering the patient information regarding the respective clinical procedures. Explanation and subsequent demystification are likely to facilitate diagnosis and treatment. As Alarcon (1995) states, "...the clinician-patient encounter realises culture" (p. 455). Both patient and clinician embody their socio-cultural contexts. Each takes with him/her a socio-cultural history which impacts on interpersonal communication and understanding. It is essential for the clinician to recognise this and develop sensitive and open-minded clinical practices. Such an approach requires a certain level of skill. As Mezzich points out, the successful application of the cultural formulation and other cultural components of the DSM-IV depends on relevant clinical training and such training has been widely encouraged "...on the grounds that it leads to better treatment outcomes" (Alarcon, p. 655). So in order for changes to the DSM to be effective, clinicians may require guidance in their practical application.

While the changes, in the direction of cultural understanding, incorporated into the DSM-IV may seem substantial they represent only a portion of those recommended by the committee. Lewis-Fernandez & Kleinman (1995) state:

"The cultural additions to the General Introduction and the 'Cultural features' of individual disorders, based on a large body of scholarship were cut down dramatically and their critical emphasis eliminated, typically resulting in

superficial commentaries that are often empty of specific content...This pattern of decisions denotes a general policy. It suggests that the editors of the DSM-IV may not really be interested in the cultural validation of the manual and seem unwilling to accord the same serious consideration to cultural data as is given to other data sources (p. 439).

As noted by Lewis-Fernandez and Kleinman, among the rejected recommendations were the three suggested Western “culture-bound” syndromes: Namely, Anorexia Nervosa, Chronic Fatigue Syndrome and Dissociative Identity Disorder. The DSM-IV has essentially retained the view that the disorders listed in main part of the manual (i.e. within the five axes) are universal. Disorders considered to be non-Western are included in the glossary of culture-bound syndromes. According to Lewis-Fernandez and Kleinman those involved in designing the DSM-IV ultimately decided on a watered down cultural component which seeks to perpetuate the view that difference and heterogeneity are superficial and unimportant. While some commentators would view the DSM-IV as the product of a deeper understanding and more open-minded consideration of the relationship between culture and mental health, Lewis-Fernandez and Kleinman claim, in contrast, that “It is clear that recent theoretical and research changes in cultural psychiatry...have not permeated the leadership of U.S. psychiatry” (p. 445).

Alarcon (1995) claims that there are inadequacies in the DSM-IV’s approach to the understanding and delineation of personality disorders. He points out that the modes of expression of some aspects of behaviour are dependent on ones socio-cultural environment, particularly those aspects of behaviour which are mediated by personality. However with regard to the particular symptom patterns of the personality disorders, as outlined in the DSM-IV, the socio-cultural nature of personality seems to have been overlooked. According to Alarcon the personality disorders outlined in the manual are relative to Western derived behavioural and social standards and such standards should not be treated as universal measures of normality. As noted by Alarcon borderline personality disorder and multiple personality disorder alongwith hypoglycemia and chronic fatigue syndrome are representative of the complex relationship between culture and the diagnostic process. However the complexity of this relationship is not captured by the DSM-IV’s approach to the delineation of these disorders.

Importantly Alarcon suggests that one of the primary benefits of the cultural components of the DSM-IV will be the increased awareness by clinicians of the cultural dimension of mental illness and a subsequent improvement in treatment efficacy. This may be more important than the fine detail of these additions which will no doubt require some modification after their utilisation in clinical situations. Alarcon states: "A cultural view of the diagnostic process makes it possible to see through the patient's identified 'symptoms' some of the cultural influences that can then help to weigh the clinical evidence more objectively" (p. 461).

### *CULTURE AND DIAGNOSIS*

There is no doubt that the Task Force involved in the development of the DSM-IV was committed to the goal of producing a more culture-sensitive and cross-culturally effective diagnostic system. Whether or not this goal has been realised is a question dependent on both empirical and theoretical facts. An obvious mark of its success will be its utility in clinical settings. However at this point in time it is probably too early to draw any firm conclusions. And, quite independently of such empirical outcomes, there remain some important theoretical issues which impact on the general cross-cultural applicability of the DSM-IV. First and foremost is the question of whether disorders such as depression and schizophrenia are universal. Because the latest version of the DSM is fundamentally equivalent to the DSM-III and DSM-III-R. Syndromes delineated in the main axes are implicitly contrasted with the culture-bound syndromes listed in the appendix (although no such list was provided in the earlier manuals). The central question here is: Is the idea of a universal diagnostic manual of mental disorders conceptually sound? Given the diversity of mental disorder one must consider the possibility that a manual for universal use is undesirable on the grounds that the quest for universality will lead necessarily to inaccuracies. Kirmayer (1991) states, "If culture is basic to the origins and form of psychiatric distress, then the project of a culture-free 'universal' psychiatric nosology is ill-conceived." (p. 26). And, "Clearly no single classificatory system will suffice for all purposes: different diagnostic approaches are needed to address different clinical concerns." (p. 27).

Kirmayer makes these remarks in the context of a discussion of the Japanese syndrome *Taijin Kyofusho* (TKS), a mental disorder characterised by a fear of interpersonal contact and social situations. He notes that while TKS is characterised by a number of culture-specific symptoms, most people who receive its diagnosis would also fulfil the criteria in the DSM-III for social phobia. This raises a number of questions: Is TKS social phobia? Which diagnosis is correct? And: Are both diagnoses valid? According to Kirmayer different contexts demand different diagnostic systems because mental disorders are culturally defined and culturally realised. For a Japanese person TKS is the best explanation because it explains the symptoms with reference to the social settings in which they have arisen and to which they are inextricably linked. As Kirmayer explains, the most culturally unique aspect of TKS is a preoccupation with the comfort of others which appears to develop out of the culturally accepted practice of regarding others with sensitivity. So the disorder is an expression of cultural norms, albeit in an extreme form.<sup>5</sup>

The question of whether a disorder such as TKS should be subsumed into a Western conception of psychopathology is complex. Even if empirical research reveals common underlying neurophysiological causes, such subsumption would inevitably result in a loss of data. It may also result in less effective treatment practices. However it could perhaps highlight similarities across cultures; similarities which might otherwise be overlooked. Kirmayer suggests that the quest for a universal classification system is illfounded and if this is the case then the DSM-IV may prove no more effective in cross-cultural situations than its earlier renditions. It is necessary to note that Kirmayer's remarks about the classification of psychopathology were made with regard to the DSM-III-R. In the DSM-IV, TKS is included in the list of culture-bound syndromes. While this represents a move towards cross-cultural understanding, as mentioned above the disorders outlined in the main body of the manual are thereby presented as universal. So, Kirmayer would probably criticise the DSM-IV on similar grounds.

As discussed in the second chapter the difficulty of classifying psychopathologies lies in the complexity of the subject matter. Fabrega (1987) states:

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<sup>5</sup> *Taijin Kyofusho* is discussed again later in the section on culture-bound syndromes.



If human illnesses were like plants or animals, that is, like concrete, fully formed, and static biological entities that existed in nature as discrete and discontinuous phenomena, hence easily identified through ones sensory apparatus, then diagnosis would conform nicely to biological classification...However as already indicated, in a certain sense general medical and psychiatric illnesses, as construed in contemporary biomedical theory, are first and foremost conceptual and/or abstract objects that are manifest in behaving individuals. Behaviour is not an object, but a set of actions that involve intentions, motives, and purposes, all of which are conditioned by social and cultural conventions. (p. 385)

While for some this remains a moot point, for many it is uncontentious. The willingness of the DSM-IV Task Force to investigate cultural factors and accordingly modify the manual shows an acceptance of a significant connection between culture and psychopathology. However there is an apparent reluctance to consider the possibility that disorders which are prevalent in the West are also culturally shaped. The universalist directive persists, albeit in a toned down presentation. The concept of fixed illness objects is, for whatever reason, attractive but as Fabrega suggests it is misguided because of the nature of the phenomena in question. Stein (1993) discusses the difficulty of drawing a definitive distinction between disease and health (not conceptually but with regard to the ascription of conditions to one or other category). He notes that the question of what is to be labelled disease rests on the value placed on their absence and decisions about the need for clinical intervention. Such decisions may vary across cultures. But importantly, Stein also lays claim to a substantial amount of cross-cultural agreement on what is valued and disvalued and what is correspondingly considered to be pathological.

One study which clearly supports this view was documented by Altshuler et al. (1988). It involved the comparison of diagnoses carried out by Western psychiatrists using the DSM-III and by Chinese psychiatrists using their own diagnostic manual. The study, carried out in an outpatient clinic in Shanghai, gave dual diagnoses to over one hundred patients and then compared the two diagnoses of each patient. An impressive 75% of diagnoses were reported to be in agreement. The most significant difference was in the diagnosis of depression. Nearly half of the patients who were given a DSM-III-based diagnosis of depression were differently diagnosed by the Chinese psychiatrists. Most who presented with predominantly somatic symptoms were diagnosed with

neurasthenia or anxiety disorder. And all of the patients given a diagnosis of major depression, with delusions or hallucinations (according to the DSM-III) were diagnosed, by the Chinese psychiatrists, as schizophrenic. The only other major difference was in the diagnosis of adjustment disorder which does not appear in the Chinese classification system. Hence the 10 patients who received this diagnosis from the Western psychiatrists received different diagnoses from the Chinese physicians. In all, five different categories were used to diagnose these individuals.

In interpreting these findings it is important to note that the Chinese diagnostic manual is based in part on the DSM-III. The similarities between the two manuals are reflected in the results of this study. Without this extent of overlap the comparison would have been significantly more difficult. What this study revealed, most notably, is that the Chinese psychiatrists employed a similar diagnostic tool as their Western counterparts and that they used it in a similar way. However there were also important differences some of which reflect disparity between the diagnostic manuals and some of which are the result of more subtle cultural incongruence. Overall, results of this study appear to support Stein's claim that there is significant agreement across cultures on what are considered to be pathological mental phenomena. If this is so, then a universal diagnostic manual may be an appropriate objective. It is essential however to acknowledge the impact of Western ideas and medical practices on lesser developed nations such as China. As mentioned, the Chinese diagnostic manual was developed in accordance with the DSM-III and hence this study was not a comparison between Western and Chinese ideologies. But even so, if a manual such as this is being used effectively in China it would seem that there is significant correspondence between the Chinese approach to the understanding of mental disorder, and the Western approach.

As noted though, the most significant difference was the Chinese clinicians' tendency to acknowledge somatic symptoms through diagnoses of neurasthenia and anxiety rather than depression. As will be discussed in the last section the presentation of somatic symptoms in depression, in Asian populations has been widely acknowledged. Culture-bound syndromes are another interesting example of cultural differences in the manifestation of psychopathology.

## CULTURE-BOUND SYNDROMES

Reference to culture-specific syndromes can be found as far back as two hundred years. In 1770 Captain James Cook documented the occurrence of *amok* among Malaysian people, a condition characterised by the sudden onset of violent and often homicidal behaviour (Levine & Gaw, 1995).<sup>6</sup> About a century later, Blonk described *koro*, a syndrome found in several parts of Asia, which is characterised by an intense fear of genital retraction and subsequent death (Levine & Gaw, 1995). According to Levine and Gaw, culture-specific mental disorders have been known by a variety of terms. For example, 'exotic psychoses,' 'ethnic neuroses,' and 'psychogenic psychoses' are all terms that have been used to refer to them in the past. And more recently they have been referred to as (the wordy) 'syndromes not seen in Western culture' and 'folk diagnostic categories.'

The term 'culture-bound syndrome' was first used by Yap (1951) (Aderibigbe & Pandurangi, 1995), and has since become the term of choice for culture-specific mental disorders. However, as noted by Levine and Gaw (1995), one problem with this expression is that it suggests that syndromes are limited to a particular culture, whereas many are found in a variety of socio-cultural groups. Nonetheless, this is the term found in the DSM-IV which lists in an appendix, a number of culture-bound syndromes. According to the DSM-IV the term 'culture-bound syndrome' indicates:

...recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses' or at least afflictions, and most have local names...culture-bound syndromes are generally limited to specific societies or culture areas and are localised, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (p. 844).

The DSM-IV provides descriptions of 25 culture-bound syndromes, some of which are discussed below.<sup>7</sup> All of the descriptions are condensed versions of those provided in the DSM-IV and much is copied directly.

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<sup>6</sup> This is the origin of the expression 'running amok' which is sometimes used to describe wild and uncontrolled behaviour.

<sup>7</sup> The culture-bound syndromes which I discuss were chosen because they are some of the most commonly mentioned conditions in the literature.

### *Amok*

A dissociative episode characterised by a period of brooding followed by an outburst of violent, aggressive, or homicidal behaviour directed at people and objects. The episode tends to be precipitated by a perceived slight or insult and seems to be prevalent only among males. The episode is often accompanied by persecutory ideas, automatism, amnesia, exhaustion, and a return to premorbid state following the episode. It was first reported in Malaysia but similar patterns of behaviour have since been reported in a number of other countries.

### *Ataque de nervios*

An idiom of distress principally reported among Latinos from the Caribbean, but recognised among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest, and verbal or physical aggression. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some attacks. A general feature of the condition is a sense of being out of control. *Ataques de nervios* frequently occur as a direct result of a stressful event relating to the family (e.g. news of a death).

### *Dhat*

A folk diagnostic term used in India to refer to severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, and feelings of weakness and exhaustion. Similar to syndromes reported in Sri Lanka and China.

### *Ghost sickness*

A preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes. Various symptoms can be attributed to ghost sickness, including bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation.

### ***Koro***

A term that refers to an episode of sudden and intense anxiety that the penis (or, in females, the vulva and nipples) will recede into the body and possibly cause death. The syndrome is reported in south and east Asia, where it is known by a variety of local terms, such as *shuk yang* (Chinese) and *rok-joo* (Thai). At times koro occurs in localised epidemic form in east Asian areas and it is occasionally found in the West. This diagnosis is included in the *Chinese Classification of Mental Disorders*.

### ***Latah***

Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trance like behaviour. The term latah is of Malaysian origin, but the syndrome has been found in many parts of the world including Thailand, Japan and the Philippines. In Malaysia it is more frequent among middle-aged women.

### ***Taijin kyofusho***

A culturally distinctive phobia in Japan, in some ways resembling Social Phobia in DSM-IV. This syndrome refers to an individual's intense fear that his or her body, its parts or its functions, displease, embarrass, or are offensive to other people in appearance, odour, facial expressions, or movements. This syndrome is included in the official Japanese diagnostic system for mental disorders.

### ***Implications of the culture-bound syndromes***

Clearly culture-bound syndromes embody a wide range of diverse phenomena in a variety of cultural settings. As mentioned, those described above are just a few of those listed in the DSM-IV and there are many more that are not included in the manual. Simons & Hughes (1993) provide a comprehensive list of culture-bound syndromes which documents 185 different conditions. Hence the need for the DSM-IV to limit its coverage to those which are considered to be well-researched, and most relevant to North American clinical practice (as stated in the manual).

Interestingly the DSM-IV acknowledges, in its introduction to the glossary of culture-bound syndromes, that some of the disorders outlined in the *main* text, have by some theorists been construed as culture-bound. It gives the examples of Anorexia Nervosa and Dissociative Identity Disorder both of which are apparently rare or absent in non-industrialised cultures. However, despite this admission it is noteworthy that these disorders have remained in the main text, and that alongwith all the other disorders therein, they stand in contrast to the list of culture-bound syndromes found in the appendix. This is consistent with the underlying bio-medical conception of mental disorder which sees the syndromes in the main text as cross-culturally immutable, based on the proposition that the core of intra-organismic dysfunction is invariant across diverse socio-cultural groups.

As noted by Levine and Gaw (1995), culture-bound syndromes provide a window to the facilitation of a deeper understanding of the interplay between psychopathology and socio-cultural factors. In particular they provide an excellent means for examining the roles of psychosocial and biological variables. Basically there are two contrasting interpretations of culture-bound syndromes. One is that they are simply superficially different manifestations of ubiquitous underlying pathology, as delineated by Western nosologies such as the DSM-IV. And the other, that they are discrete syndromes which can not be subsumed under Western diagnostic categories but rather, must stand along side them. Almost a century ago, Kraepelin proposed that *amok* in Indonesia was probably catatonia or epilepsy. And *Windigo* a condition observed in North American Indians has been described by various researchers as schizophrenia, anxiety, hysteria and depression (Littlewood & Lipsedge, 1985).

Several of the syndrome descriptions in the DSM-IV culture-bound syndrome glossary, include suggested associations with major diagnostic categories. For instance, it is proposed that some cases of *amok* may occur in the midst of a brief psychotic episode or that they may signify the onset or intensification of chronic psychosis. In such cases *amok* might be interpreted as a culturally shaped expression of a universal type of psychopathology. While *amok* may lead to dire outcomes, in Malaysia where it is widely reported, it is generally considered to be an acceptable form of aggressive behaviour (Aderibigbe & Pandurangi, 1995). However, as noted by these authors, it is only considered appropriate in response to a certain type of social circumstance.

Typically *amok* is seen as an appropriate response to political oppression. In this sense it would seem to be a strongly culturally mediated disorder.

And noted in the DSM-IV is the similarity of *Ataque de nervios*, to a panic attack, the primary symptom of panic disorder. However also noted are the important differences: Firstly, that the intense fear and apprehension which characterise a Panic Attack are absent in *Ataques de nervios* and secondly, that the latter are usually associated with a specific precipitating event. Also in some populations *Ataques de nervios* are remarkably common. One study of residents of Puerto Rico found that sixteen percent of those surveyed reported that they had had an *ataque* at some point during their lifetime (Rubel, 1993). This figure contrasts sharply with the prevalence rate of panic disorder, which has been estimated at about 0.7 percent for men and a little over 1 percent for women (Myers, Weissman, Tischler, Holzer, Leaf, Orvaschel et al., (1984).<sup>8</sup> *Ataque de nervios*, it seems, is a socio-culturally mediated response to a particular type of stress. The familial events with which it is typically associated include injury to, or death of family member, substance abuse and disagreements between family members (Rubel, 1993).

*Taijin kyofusho* is likened in the DSM-IV to social phobia as it is essentially a fear of social interaction and social situations. The term itself is often translated as anthropophobia (Kirmayer, 1991), suggesting an anxiety centred on contact with other human beings. However as noted by Kirmayer (1991) (and mentioned earlier in the chapter), *taijin kyofusho* has a number of culturally distinct features. In particular this syndrome is rather physically centred with a fear of blushing and a fear of emitting an offensive odour among the most commonly seen symptoms. As discussed earlier Kirmayer argues that due to these rather distinct culture-relative features, *taijin kyofusho* is best understood in relation to the context that it occurs. His discussion of Japanese culture demonstrates the intimate connection between cultural variables and *taijin kyofusho*. For example, in Japan eye contact is considered to be inappropriate in many social situations. And more generally, the outward portrayal of the self is seen as immensely important in social interaction (Kirmayer, 1991).

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<sup>8</sup> Obviously I am comparing incidence with prevalence here, however the comparison is nonetheless useful, showing a significant difference.

Levine and Gaw (1995) suggest that: "The pathophysiology of this disorder may be the same as that of social phobia, with a higher prevalence among the Japanese because of values inherent to the culture that emphasise the importance of proper behaviour in all situations" (p. 530). This is an example of the now familiar idea that culture-bound syndromes are simply superficially different variants of universal forms of pathology. Whether this is true of *taijin kyofusho* remains to be seen. Too little is known of the underlying physiological correlates to determine the relationship between it and social phobia at this time. Interestingly though, following the same argument, social phobia as it is delineated in the DSM-IV may be a Western-bound form of social-focused psychopathology.

While some theorists such as Levine and Gaw, argue that culture-bound syndromes are socially coloured manifestations of ubiquitous patterns of underlying pathophysiology, others such as Kirmayer see the socio-cultural aspects of mental disorder as inextricably connected to the underlying pathophysiology and therefore as defining features of the condition. He states: "...for many culture-bound syndromes, cultural beliefs or rules and patterns of interaction are constitutive of the disorder" (1991, p. 26). According to this view, cultural factors are not merely an overlay of variance upon uniform patterns of psychopathology, but are rather an integral part of a complex system of psychopathology. To assume the same pathophysiology in both social phobia and *taijin kyofusho* is to ignore the connection between physiological, psychological and socio-cultural variables all of which arguably interact in the manifestation of mental disorder.

While many culture-bound syndromes resemble many of the primary syndromes detailed in the DSM-IV, even those with the greatest similarity exhibit striking differences. This does not mean that comparisons are therefore futile, but simply that one should not make hasty assumptions about their relationships to those primary syndromes. A major problem with such comparison is that researchers often assume that disorders in the DSM-IV are universal and therefore culture-bound syndromes are subsumed into 'universal' categories. This underestimates the cultural aspects of Western delineated syndromes thereby promoting the idea that while many other ethnic groups have culturally influenced categories of psychopathology, we in the West do not.



## DEPRESSION

Affective disorders are the 'common cold' of major psychopathologies (Gupta, 1993). Their prevalence and subsequent impact on society (at least in the West) is unmatched by any other mental disorder (Lehtinen & Joukamaa 1995). The DSM-IV lists two major mood disorders, major or unipolar depression and bipolar disorder. The DSM-IV diagnostic criteria for major depression are sad, low mood and/or loss of interest and pleasure in usual activities, coupled with disturbances of weight, appetite, sleep and activity level. The symptoms must be present almost every day for at least two weeks. Bipolar disorder is characterised by similar episodes of depression alongwith periods of manic symptomatology which includes, elated or irritable mood, talkativeness and hyperactivity. Both unipolar and bipolar disorder are discussed in this section although the latter receives considerably less attention due to its paucity in the literature.

### *Early studies*

During the early 1900s Kraepelin carried out the first systematic studies of depression in a non-Western context (Jilek, 1995). He reported that among hospitalised Javanese, chronic and serious depressive states were rare, and suicide attempts almost unheard of. More frequent, were periods of confused excitement which were typically of short duration. Kraepelin concluded that manic-depression was unusual but not absent in this population while major depression was extremely rare. Kraepelin noted that self-accusations of sinfulness which were common indicators of depression in European societies were never voiced by Javanese patients. This finding while unremarkable, is nonetheless interesting in that it represents one of the earliest references to the relationship of culture-bound belief systems to psychopathology. The self-deprecation evident in the depressive symptomatology of Kraepelin's European patients was believed to be closely linked to Judaeo-Christian theology.

According to Jilek (1995) more recent research confirms Kraepelin's findings - that feelings of guilt linked to sinfulness and worthlessness are not seen in depressives transculturally. He suggests, however, that guilt is not absent in non-Western

depressive states, but rather that it takes a different form. For example in societies instilled with Confucian ethics, guilt may arise from the neglect of family and the failure to live up to familial expectation. And in Hinduist and Islamic cultures guilt may centre around the failure to conduct religious rituals and obey religious creeds. This is a clear example of the way in which the 'content' of depressive symptoms may vary across cultures. Those who favour a universalist interpretation of cross-cultural differences in mental disorders, typically claim that although there may be superficial differences in the expression of some symptoms (such as the basis and form of ones guilt), the same basic symptoms will be found.

While Kraepelin's pioneering studies of depression in Indonesia yielded some interesting results they have been criticised - for the same reason that other similar studies have been criticised - for focusing solely on a hospitalised population. This subject group is not representative; it consisted of those who lived in or near urban areas. Following a study of depression in Indonesia, Pfeiffer (1967, in Jilek 1995) concluded that depression was not uncommon, however patients were rarely hospitalised. This highlights the inadequacy of cross-cultural studies which focus solely on hospitalised cases. As many cultures have quite different approaches to the treatment of psychopathologies it is important to take account of these approaches when designing cross-cultural investigations. This means that studies should, where possible, survey a cross-section of the population. In many developing countries, only the wealthy and educated have access to hospital-centred mental health care.

### ***Biological factors***

Familial studies and the success of neurochemical treatments for both unipolar and bipolar affective disorder suggest a significant biogenetic element in depression. Bipolar depression in particular has a strong genetic component (Nesse & Williams, 1994). In a review of data on the manifestation of bipolar depression in twins, Allen (1976) reported an average concordance rate of 72 percent in monozygotic twins and 14 percent in dizygotic twins. In contrast, the figures for unipolar depression were 40 percent and 11 percent respectively. Andreasen, Rice, Endicott, Coryell, Grove and Reich (1987) confirm that genetic factors are considerably less influential in unipolar

depression. Even so, a 40 percent concordance rate suggests that even unipolar depression has a consequential genetic component.

The increasingly successful use of drug treatments for affective disorders lends support to causal theories which revolve around changes in neurotransmitter systems. The two neurotransmitters most commonly implicated are norepinephrine and serotonin. It is believed that low levels of norepinephrine may lead to depression and high levels to mania. In contrast, low levels of serotonin (which is understood to play a regulatory role) are claimed to produce both depressive and manic symptomatology (McNeal & Cimbalic, 1986). Although pharmacological treatments of affective disorders have been and continue to be effective, the operative neural substrates are not entirely understood. While serotonin and norepinephrine are probably important, they interact with other neurochemicals forming a complex picture of neural activity; a picture which at this time is far from clear.

The interaction of biological factors with socio-cultural ones, in the manifestation of depression is complex. The assumption that a disorder with a genetic component will necessarily appear in all human populations is quite wrong. There are several physical diseases which occur only in specific locations. For example Oliver Sacks (1996) in his typically eloquent fashion describes congenital colour-blindness in the native inhabitants of some islands of Micronesia. Two more familiar examples are sickle-cell anaemia and Tay-Sachs disease. Although it is not possible to discuss these diseases in detail, they show, simply by their mere existence, that different human populations can have diseases unique to the genotype which is shared by individuals in the group. So a genetic element in a mental disorder does not necessitate universality. Moreover the genetic elements in depression are predispositions which interact with environmental factors. They are not solitary markers of causation.

Comparing psychiatry's utilisation of biological explanations, with that of evolutionary biologists, Kleinman (1988) says, "Ironically, it is the reverse of the argument evolutionary biologists advance to explain the great diversity of species world-wide.

There biology is viewed as the major source of variation” (p. 19).<sup>9</sup> It is within-species variation that underlies the process of natural selection. It is heterogeneity, not homogeneity among species which leads to phylogenetic change. Physically *Homo sapiens* demonstrate a certain amount of environmentally induced variation which as suggested earlier could be realised neurologically.

Drug treatments and related neurochemical theories are also often hailed as evidence of a primarily biological basis and hence universal incidence of depression. However, while neurochemical intervention can relieve depressive symptomatology it may not be the cause of it. Pathological sadness is likely to be associated with a particular type of neural ‘state’ but this state is not necessarily the cause of the problem. The thesis of universality based on biological etiology depends on a clear causal pathway from neural change to depressive symptoms. But arguably this has not been demonstrated. There are many other factors involved. As will be explained later, depression varies across populations; beliefs, values and customs influence its cross-cultural manifestation. And moreover, as mentioned in the previous chapter, evidence suggests that there are racial differences in responses to antidepressants (Lin et al., 1986, Sakauye, 1992) indicating that there may be differences even at the biological level.

### *Depression and culture*

As mentioned in the preceding chapter, translation is often central to cross-cultural research but typically it is not a straightforward procedure. The word ‘depressed’ has no equivalent in the languages of some cultures, for example American Indian and some South East Asian groups (Manson, 1995). And Yoruba, a Nigerian language, has only one word to denote depression, anxiety and anger (Abusah, 1993). This does not mean therefore, that these people do not experience depressive states similar to those experienced by Westerners, but it may mean that such states will be more difficult to understand from the perspective of a Western researcher. If the subjective experience of ‘feeling depressed’ is considered fundamental to a diagnosis of depression then the absence of such an experience may preclude the ascription of this diagnostic label.

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<sup>9</sup> This is stated in the context of a discussion on the biological basis of schizophrenia. Psychiatrists often assert that if a mental disorder such as schizophrenia has a strong biological basis then it will necessarily manifest similarly across cultures.

Conversely one may wish to accept a broader conception of major depression which allows for a more diverse array of symptoms; symptoms which differ from those typically seen in the West, but which retain some essential characteristics.

In a summary of findings of cross-cultural studies of mental disorder Draguns (1995) states: "Major depression is more susceptible to cultural shaping than the schizophrenic disorders" and "Both major depression and schizophrenia are characterised by a few culturally immutable symptoms" (p. 87-88). According to Draguns then, there are some depressive symptoms which occur universally and there are some that vary transculturally. He cites the WHO study published in 1983 - carried out in Canada, Iran, Japan and Switzerland - which identifies several core symptoms of major depression, including sad affect and loss of enjoyment. So these two symptoms, which are perhaps fundamental to Western conceptions of depression, were found (alongwith several others) to be equally important indicators of depression in all of these population groups. However the WHO study also found significant variation in the incidence of some symptoms - including hypochondriasis, previous depressive episode and sleep disturbance.

Westermeyer (1989) lists depressions under the heading of 'pathoplastic and culture-bound disorders' (which he defines as 'non-psychotic/non-drug/non-organic psychiatric disorders'). He says that these disorders are often referred to as 'culture-bound' because of the substantial variation in their prevalence across cultures. Westermeyer's claim is not that depression is a uniquely Western phenomenon but rather that in many cultures it may manifest very differently. That is, it is significantly influenced by cultural factors. While depression is not typically referred to as a culture-bound syndrome, the view that some depressive symptoms vary cross-culturally is widely accepted (Sartorius, Jablensky, Gulbinat & Ernberg, 1980). As mentioned in the previous chapter cross-cultural differences in the emphasis on somatic symptoms are well established. And it is this sort of variation which Westermeyer is referring to. However the extent to which differences of this nature impinge on the cross-cultural applicability of a diagnostic category such as depression is unclear. Although a depression experienced

primarily as the sensation of ‘worms crawling in the head’ or ‘noises in the ears’<sup>10</sup> may have other features in common with a Western conception of the disorder, the question arises of whether it would be better delineated as a different nosological entity.

### *Somatisation*

Undoubtedly the most striking and consistent finding of the relationship between culture and depression is the variation in somatisation. Essentially somatisation is the presentation of physical symptoms as an explanation for psychological distress (Mukherji, 1995). In other words an individual experiences bodily symptoms which are perceived as being related to, or even the cause of, the psychological problem. This type of symptomatology is uncommon in Westerners, but very common in many non-Western populations, particularly in some Asian communities. For example, Weiss et al. (1995) studied the manifestation of depression in South India and found a ‘striking’ tendency to spontaneously report somatic symptoms but to also identify depressive symptoms when probed. So, patients were more immediately aware of their physical symptoms but could recognise psychological symptoms when these were explored. Weiss et al. claim:

“Our findings provide empirical evidence that even in DSM-III-R, privileging depressive over somatoform patterns of distress in the professional nosology may be a cultural and historical artefact that is problematic for clinical practice in South Asia and probably among other groups as well”(p. 357).

They note that depression in developing countries is often referred to as ‘masked’ and suggest that equally plausible is the concept of ‘masked somatoform disorders’ in the West. Mukherji (1995) suggests that somatic symptomatology may be the most ubiquitous expression of psychological distress and he points out physical discomfort of one sort or another almost always accompanies psychological distress. Considering these facts, the suggestion that somatic symptoms simply mask depression and are not a genuine part is questionable.

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<sup>10</sup> According to Levine and Gaw (1995) symptoms of this sort have been reported by Africans as part of a folk-syndrome labelled ‘brain fag.’ They note that this syndrome and others like it have a pathophysiology similar to depression.

While the somatisation of depression has been most frequently investigated in Asia, this sort of symptom pattern has also been reported elsewhere. For example Ulusahin, Basoglu & Paykel (1994) compared depression in Britain and Turkey and found that Turkish patients typically presented somatic symptoms while British patients generally reported symptoms of, what they refer to as, 'core depression' - such as loss of interest and pleasure, and occupational impairment. Importantly the 'core depression' symptoms were found equally in both patient groups, however the Turkish patients tended to report their somatic symptoms more readily. So, although the researchers found some significant differences in symptom presentation they confirm the findings of other studies - that a core set of depressive symptoms may be universal.

The emphasis on psychological as opposed to somatic symptoms in contemporary Western conceptualisations of depression, reflects a long intellectual tradition of mind-body dualism (Manson, 1995). While Descartes' tenet of this critical distinction has been universally discredited (at least within scientific circles), the mind-body dichotomy has nonetheless remained influential. This is evidenced by the inclination of Westerners to separate mental and physical phenomenology. For example, depressed mood may be experienced only in cognitive and emotional terms with little or no attention paid to somatic symptoms. In contrast an individual with a more holistic understanding of mind and body, such as an Indian, would be more likely to attend to somatic symptoms and view them as part of a totality of experience (Varma, 1986). Hence differences across cultures in somatisation probably represent differences in folk psychologies. This illustrates the way in which belief systems may influence the manifestation of mental disorders.

Another possible reason for the emphasis of some cultures on somatic symptomatology is the negative response of many of these cultures to the expression of emotion (Chen, 1995). For instance, as mentioned in the previous chapter, in Japan a psychiatric diagnosis is often greatly stigmatised. This stigmatisation is not only attached to the individual concerned but also to the individual's immediate and extended family. Therefore, to avoid the profound consequences of a psychiatric diagnosis, both patients and physicians may emphasise somatic symptoms. Moreover in Japan and many other Asian countries the open expression of emotion, in any form, is considered socially unacceptable. "Thus a legitimate entry into the sick role in these cultures may be by the

communication of somatic or physical illness” (Mukherji, 1995, p.209). Patients may underemphasise psychological problems and overemphasise physical ones in order to facilitate a more acceptable expression of their pathology. This does not mean therefore that the physical symptoms are illusory. Rather, it suggests that people in these cultures who learn from an early age to control and conceal their emotions, will be more likely to freely express their somatic symptoms than their psychological ones.

The connection between somatisation and the devaluing of emotional expression has also been noted elsewhere. For instance in Algeria and many other Arab nations the public display of emotion is considered shameful. And, as in Japan, patients will freely discuss somatic symptoms but only reluctantly reveal their low mood (Al-Issa, 1990). In fact, Al-Issa states that, “In contrast to somatic symptoms, mood disturbance is either minor or not verbalised at all by the patients.” On what basis then were patients diagnosed as depressed? Intuitively one would assume that mood disturbance would have to be more than ‘minor’ in order for patients to receive diagnoses of affective disorder. Presumably such patients displayed the typical physiological changes commonly associated with endogenous depression, but such changes mimic those of chronic fatigue syndrome. Like many other researchers, Al-Issa refers to depression in this context as ‘masked’, downplaying the significance of somatic symptomatology. However his remark concerning the diagnosis of depression without major mood disturbance suggests in contrast, a practice of acknowledging the primacy of somatic symptoms in depression, in this population.

In an extensive analysis of the world-wide occurrence of somatisation, Mumford (1993) questions the depth of the differences between Western and non-Western cultures. He claims that such differences are often exaggerated and misinterpreted. He notes the distinction between the experience and presentation of somatic symptoms and suggests that this is often blurred or even overlooked. His central point is that clinicians often mistakenly assume that the expression of somatic symptoms accurately represents underlying experience. According to Mumford, although evidence shows undoubtedly that many non-Westerners readily communicate somatic complaints, there is little evidence to support the related, yet distinct claim, that they have a predominantly somatic *experience* of their illness. Mumford cites a number of studies comparing the experience of somatic symptoms in Britain and Pakistan, which he states reveal only



‘modest cultural differences.’ Importantly, however, the Pakistani subjects were all English speaking and from a higher socio-economic group. Hence many may have been familiar with Western conceptualisations of depression. And all studies found differences which would be considered statistically significant. Basically, Mumford’s claim that somatisation is superficial, in that it may misrepresent actual experience, has little empirical support.

### *Summary*

Research to date reveals that although some core symptoms of depression have been found in a wide variety of countries and cultures, the experience and presentation of its symptomatology vary significantly, particularly between Western and non-Western cultures. Although some core features of depression have been found across cultures, the DSM-IV criteria for depression, especially major depression, are undoubtedly biased towards a Western illness presentation. These criteria do not adequately capture the symptom configuration of those whose primary focus is somatic. The view that somatic symptoms are superficial and psychological ones fundamental to depression is more likely an artefact of Western ideology than an objective observation of actual phenomenology.

## *SUMMARY*

While the historical development of the various DSMs reveals a move, in the most recent edition, towards a more culture-sensitive approach, the DSM-IV has nonetheless retained a Western oriented bio-medical perspective which underestimates the significant influence of socio-cultural variables. As illustrated, there are a number of difficulties associated with the use of such a system in cross-cultural contexts. In particular it assumes that Western forms of psychopathology are universal thereby undermining indigenous understandings and approaches. The existence of culture-bound syndromes demonstrates the important interaction between mental disorder and socio-cultural factors. And cultural differences have also been found in the manifestation of depression, one of the DSM’s primary syndromes. The following

chapter looks in detail at the cross-cultural presentation of another primary syndrome: namely schizophrenia.

## CHAPTER 6

### *SCHIZOPHRENIA ACROSS CULTURES*

This chapter looks in detail at the cross-cultural research on schizophrenia, with the primary aim of establishing whether or not schizophrenia, as delineated by western diagnostic systems, actually occurs in non-western settings. This discussion provides a framework within which, the methodological problems which arise in this field can be explicated, and general issues such as the relationship between biological and sociological factors can be addressed. Compared to other mental disorders, the cross-cultural research on schizophrenia is substantial. One reason for this is the widespread belief that the principal cause of schizophrenia is biological dysfunction. Hence many researchers believe that compared to disorders with a lesser biological component, schizophrenia is more likely to evidence universally. Another reason is the impact that the disease has on society. Because schizophrenia is characterised by early onset and long term disability it is associated with high personal, social and economic costs. It has been estimated that the costs of the disease in the United States; including the expense of treatment and long term care, and the indirect cost of lost productivity, amount to about 2% of the gross national product (Andrews, Hall, Goldstein, Lapsley, Bartels & Silove, 1985). To date, one of the most consequential findings of cross-cultural studies of schizophrenia, is that people in developing countries who have the disease have a better prognosis than those in developed countries. If this is indeed true, this would be an important area of study in terms of understanding the disease process and developing optimal treatment.

Late last century, Kraepelin, who was the first to formally identify schizophrenia, put it under the heading of 'metabolic diseases.' Although he referred to it as 'dementia praecox,' his characterisation of the disorder is similar to contemporary descriptions and is still well regarded (Jablensky and Sartorius, 1988). Interestingly, although Kraepelin believed that dementia praecox was primarily due to biological dysfunction,

he was also mindful of the influence of culture on mental disorders and travelled to Singapore and Indonesia in order to develop his understanding of this field. His most important finding was probably the insightful realisation of the difficulties associated with cross-cultural research. He recognised the importance of developing clear clinical concepts and ensuring observer reliability - tasks which are fundamental to all good research but which are particularly important in the application of cross-cultural studies.

Despite Kraepelin's awareness of the limitations of his cross-cultural exploration, he concluded, after identifying several cases of dementia praecox in institutions in both Singapore and Indonesia, that it is a universal disease (Torrey, 1973). As noted by Torrey, Kraepelin's observations were limited to institutionalised persons who would not have been representative of the general population. Inpatients of mental hospitals were necessarily those who had had substantial contact with western culture and western technology - they generally lived in the colonially driven urban areas and were often employed by the colonists. As will be demonstrated below, this sort of investigative error was commonly seen in early cross-cultural studies in psychology. In light of the shortcomings of Kraepelin's work his conclusion of the universality of dementia praecox was obviously premature. This is confirmed by the fact that almost a century later, the question of the universality of the disorder is still being avidly debated.

## *WHAT IS SCHIZOPHRENIA?*

In 1896, Kraepelin wrote:

"We designate as dementia praecox the development of a simple, more or less pervasive, state of mental weakness, which manifests itself as an acute or subacute mental disorder. The course of this disease process can exhibit very different patterns...This behaviour indicates, I believe, that in all likelihood we are dealing with organic change in the brain" (Jablensky & Sartorius, 1988).

Although, over the years, many clinicians and theorists have commended Kraepelin on this definition, it is undoubtedly obscure. Its appeal lies primarily in its flexibility, serving as testimony to the fact that schizophrenia is a complex and perhaps elusive

concept. More specifically, he believed the following symptoms to be typical of dementia praecox: hallucinations, delusions, decrease in attention to outside stimuli, lack of curiosity, disordered thought, diminished insight and judgement, affective blunting and negativism. He noted that its initial onset was usually during early adulthood and believed this to be an important defining feature. The definition of schizophrenia offered in the DSM-IV is remarkably similar. Here it is classified under the heading of psychotic disorders and its symptoms are as follows: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, social withdrawal, and negative symptoms (which are, restricted affect, restriction of fluency of thought and speech, and diminished avolition). In order to fulfil the diagnosis, at least two of these symptoms must be present for one month and some signs of the disorder must be present for at least six months (APA, 1994).

Although Kraepelin's original definition of schizophrenia and the definition found in the latest DSM are very similar, there have throughout the century, been several other quite different approaches to the definition of the disorder. The most consequential of these were the definitions of Bleuler (1950) and Schneider (1959). Bleuler recognised the heterogeneity of the condition and broadened the definition to include various subtypes; the unifying feature of which was a loss of integration of mental functions. He described the primary symptoms as altered associations, altered affect, ambivalence and autism. Schneider, on the other hand, was interested in the 'core' indicators of the disease which he referred to as first rank symptoms. In an attempt to clarify the concept of schizophrenia, Schneider's goal was to find symptoms which could be described as definitive markers of the disorder. His central claim was that delusions and hallucinations are the core features of schizophrenia. This view finds little support today, as it is now commonly believed that schizophrenia may occur without this sort of symptomatology.

Discussions about the 'essence' of schizophrenia continue today. Due to the complex nature of the disorder and its diverse symptomatology its validity as a diagnostic label has frequently been questioned (e.g. Bentall et al. 1988; Heinrichs, 1993; Helmchen, 1988). However, as stated by Andreasen (1987):

Almost anyone who works carefully with patients suffering from this illness will concur that it is a 'real disease', but will be hard pressed to define it in a way likely to lead to universal consensus (p. 10).

And Kendell (1972) wrote:

...the only defining characteristic available to us is the syndrome itself. In our present state of knowledge, our criteria for a diagnosis can only be the typical clinical features of schizophrenia (p. 385).

As is the case with many psychological disorders, a precise and rigid definition of schizophrenia is perhaps impossible. However, whatever definition one decides to utilise, it is essential to be aware of the issues which surround this discussion. If schizophrenia is not one disorder, but rather many related yet distinct and more narrowly defined conditions, then this would undoubtedly influence the design and outcome of research on schizophrenia. How can the search for schizophrenia in other cultures be undertaken if there is uncertainty about the nature and boundaries of schizophrenic symptoms? Another important consequence of conceptual uncertainty, is the impact on treatment. The efficacy of pharmacological treatments, particularly, relies on diagnostic accuracy. And one must also consider the wider significance of the diagnostic label and the possible ramifications of misdiagnosis.

Schizophrenia is a serious mental disorder inasmuch as it is usually associated with serious social and/or occupational dysfunction. With a lifetime risk, in western societies, of slightly greater than one percent, schizophrenia accounts for approximately one fifth of all serious and long-term disability (Jablensky, 1989).<sup>11</sup> As such, it has throughout this century, received considerable attention from psychologists, psychiatrists and anthropologists. The cross-cultural manifestations of the disease have been a primary focus of the research, as well as etiological factors, and the reliability and validity of the diagnostic label. However despite the rigorous and resolute approach of researchers, there is much that remains in question, and schizophrenia retains its primordial mystique. As stated by Jablensky and Sartorius (1988), "Few disorders have

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<sup>11</sup> It should be noted that while the western/non-western dichotomy is often a useful and accurate way of classifying cultural groups, there may be substantial differences within these domains. For instance, compared to other parts of Europe, some Scandinavian communities are reported to have very high rates of schizophrenia (Kleinman, 1988). And a number of researchers have suggested that the rates of schizophrenia differ according to peoples' socio-economic status within a given community (Elnagar et al, 1971; Minas et al. 1985; Odegard, 1959; Rose, 1964).

been investigated with such persistence and with so few tangible results as schizophrenia" (p. 65).

## *BIOLOGICAL FACTORS*

Doran, Breier, and Roy (1986) suggest: "Such characteristics as pharmacologic responsivity and genetic transmission and the development of biological markers may be the prospective cornerstones for validating the diagnosis of schizophrenia" (p. 29). This has been, and remains, the hope of many who seek clarification of schizophrenia as both a nosological concept and a disease. However, studies investigating the neurobiological abnormalities which may play a part in the onset of schizophrenia, have been fraught with methodological difficulties (Minas, Jackson, Doherty, & McGorry, 1985). While the "dopamine hypothesis" (i.e., that essentially schizophrenia is due to dopaminergic overactivity) has received considerable attention, there have been no major advancements since its inception many years ago. The dopamine hypothesis arose primarily from the success of antipsychotics in the treatment of schizophrenia. These drugs, in addition to relieving some of the symptoms of schizophrenia, may also cause Parkinsonism, which is commonly believed to be caused by a dopamine deficiency in the basal ganglia (Murray, 1979). Hence it was reasoned that schizophrenia is associated with excess dopamine in this region. Other evidence in support of the theory comes from schizophrenic-like symptoms in an amphetamine induced psychosis; amphetamines are believed to produce an increase in synaptic dopamine (Murray, 1979).

The search for the biological substrates of schizophrenia has been driven in part by the results of genetic studies which show unequivocally that genetic factors play a role in the etiology of the disorder. While twin and other familial studies reveal a genetic component the physiological instantiation of this component has not been identified (Lyons, Kremen, Tsuang, & Faraone, 1989). Twin studies reveal average concordance figures of 50% for monozygotic pairs and 17% for dizygotic (Minas et al, 1985). According to Shields (1978) there is no substantial difference in concordance between monozygotic twins reared together and those reared apart.

This is not to say however that environmental factors do not also play an important role in the etiology of schizophrenia. McGue and Gottesman (1989) suggest that the concordance rate for monozygotic twins is considerably less than 100 percent (they suggest that it is about 44%) meaning that environmental variables also have considerable etiological significance.

The interaction of biological factors with socio-cultural ones, in the manifestation of schizophrenia is complex. As detailed in the previous chapter, in the discussion of depression, the assumption that a disorder with a genetic component will necessarily appear identically in all human populations is unfounded. As explained, there are several physical conditions which are found only in specific populations. These conditions demonstrate by their mere existence, that different human populations can have diseases unique to their genotype. A genetic element in a mental disorder does not necessitate universality. Moreover, like the genetic component of depression, the genetic element in schizophrenia is arguably a predisposition which interacts with environmental factors, rather than a solitary marker of causation.

In an early study, Brown and Birley (1968) demonstrated the importance of stressful life events in the onset of schizophrenia, a finding which has received considerable recognition. And other studies have revealed a complex interaction between the manifestation of schizophrenia and particular environmental variables such as socio-economic status (e.g. Dohrenwend, Levav, Schwartz, Naveh, Link et al., 1992). Research in these areas suggests that even if human beings in all regions of the world are genetically equivalent, there may yet be differences in the manifestation of schizophrenia due to environmental variation. Some researchers argue that if schizophrenia is essentially the result of neurological malfunction then there will be few if any transcultural differences in symptomatology. However to date the neurochemical pathways of schizophrenia are not fully understood. Increases in synaptic dopamine may simply be correlates, not causes, of the disorder. Hence any argument asserting universality of schizophrenia based on biological etiology is unquestionably premature.



## *EARLY CROSS-CULTURAL STUDIES*

Early cross-cultural research on Schizophrenia deserves only brief acknowledgement. Although some interesting work has been carried out over the past century, it was not until the 1970s that studies with good methodological design emerged. Much of the early research utilised a very broad interpretation of the concept of schizophrenia - including cases which would not fall within the modern diagnostic category. And often cultures were described as 'primitive' when in fact they had been significantly influenced by Western civilisation.

Throughout the first half of the century the question of the universality of schizophrenia received considerable attention. A common outcome of the various investigations was that the incidence of schizophrenia was found to correlate with the amount of Western influence that people had been exposed to. Three studies carried out between 1929 and 1937, in New Guinea, Brazil and the Congo reported that no cases of schizophrenia were found in natives who had little or no contact with Europeans (Torrey, 1973). Other researchers (; Dhunjibhoy, 1930; Shelley & Watson, 1936; Rao, 1966) complimented these findings, concluding, after studying cases in Africa and India, that European or Western influences increased the rates of schizophrenia.

A review by Benedict and Jacks (1954) seemed to change the tide of opinion, convincing many that schizophrenia was beyond doubt, universal. The review, entitled, 'Mental illness in primitive societies,' included studies on five cultures: New Zealand Maori, native Hawaiian, South African Bantu, Africans in Kenya and Australian Aborigines. All five studies presented data which was alleged to prove unequivocally, the universality of schizophrenia. However as argued convincingly by Torrey (1973), all five studies had such serious methodological problems that the review of Benedict and Jacks, which relies on their data, must not be given the recognition which it received 40 years ago. While the populations in the five countries were described as primitive, none would have met today's criteria for such a label. In fact, most cases were hospitalised patients in urban areas who had to a large extent been 'Westernised'.

Another problem with the studies referred to in the review, and one which was typical of other cross-cultural studies from this era, was that the concept of 'schizophrenia' was used so loosely, so as to refer, in some instances, to all types of mental disorder. The investigation of Carothers (1951) into the extent of manifestation of schizophrenia among Africans in Kenya was actually a report on the total incidence of all forms of mental illness among the native people of the region. This approach was undoubtedly related to his views on the overall mental inferiority of black people. Carothers theorised that the mental deficiencies of Africans were due to underdevelopment of their forebrains, describing their behaviour as similar to that of "leucotomized Europeans". Considering comments such as this, it is surprising that Carothers' work was ever taken seriously.

Despite the shortcomings of the Benedict and Jacks review, it has frequently been cited, without question, as testimony to the universality of schizophrenia, with many later studies basing their hypotheses on its premise. According to Torrey (1973) this view of schizophrenia has greatly influenced more recent studies which often sought to confirm the already known fact of its universality. Lin's (1953) study of schizophrenia in three communities in Taiwan reported a prevalence of 2 per 1000 which approximates prevalence figures in the west. Measuring the prevalence of schizophrenia in indigenous inhabitants of Taiwan, Rin and Lin (1962) reported a rate of .9 per 1000. They noted however that most of the cases had an acute onset, short duration and often a complete remission which is a very different symptom profile from that found characteristically in the West.

Burton-Bradley (1969) studied schizophrenia in New Guinea where he had practised psychiatry for 15 years and reported that although it seemed relatively common among the native inhabitants it almost always occurred in people who lived in urban areas. He claimed that it was rarely seen in the "so-called bush individual". He did say, however, that sometimes people who had recently left their villages to settle in the city, exhibited the symptoms of acute schizophrenia, which often abated if the individuals returned to their rural environment.

Unfortunately few conclusions can be drawn from these early studies. Many of the claims which have been made by the various researchers are based on unsound

methodology, which is characterised by poor definitions and shoddy fieldwork. While schizophrenia has been reported in many diverse environments, little work has been undertaken in cultures that are largely unaffected by the West. One could argue that the degree of Western influence is not necessarily consequential. After all, many non-Western communities which have been colonised or influenced in other ways, by Western practices, retain a strong cultural identity and may seem largely unaffected by invading customs. Or what may be of more interest to some researchers is whether or not schizophrenia occurs across races, regardless of social environment. It would seem that the answer to this question is positive; it has been exhibited in many different people from different parts of the world. It may however be more common in people who live in, or are at least exposed to, the industrialised West.

### *THE WHO CROSS-CULTURAL RESEARCH PROGRAMME*

The International Pilot Study of Schizophrenia (IPSS) conducted by the World Health Organisation (WHO) represented a significant improvement in the quality of cross-cultural psychological research. Carried out during the early 1970s, in nine countries, it set out to show that there are core features of schizophrenia that occur similarly in primitive and modern, Western and non-Western societies (WHO 1973, 1979). To ensure the standardisation of diagnostic systems across countries, the participating psychiatrists in the various centres were all trained in the use of the same diagnostic instrument (the Present State Examination or PSE), which had been translated into the various local languages. The IPSS demonstrated that in all nine centres, groups of psychotic patients could be found, who exhibited the symptoms characteristic of schizophrenia.

However, while this result may seem impressive and conclusive, as noted by Kleinman (1988), the IPSS used strict inclusion and exclusion criteria resulting in an artificially homogenous sample. Kleinman claims that the "...similarity was an artefact of the methodology." (p. 19). Patients who would have been more likely to show different symptom patterns were excluded from the study from the outset. So, although subjects who met the rigid criteria for diagnosis, were found across cultures, it must be noted that those who would have shown the greatest diversity, and would perhaps have

challenged the diagnostic approach, were not included in the final sample. This highlights a difficulty with this sort of research. A cross-cultural study of a mental disorder will necessarily require definition of the particular disorder and corresponding guidelines for sample delineation which is relative to a particular diagnostic system. However, ideally the possibility of cross-cultural differences should also be incorporated into the methodology, so that if there *are* differences, they will be revealed. The WHO study was a search for similarity, which it found, but it was a limited search within a predetermined sample.

Admittedly the IPSS was designed to find people with prototypical schizophrenic symptomatology and hence there was little sense in including patients who would not have met these criteria. On the other hand, however, results from this sort of investigation which reveals cross-cultural similarities, should not overshadow the potential impact of cross-cultural diversity. One must remember that the similarity discovered here was the primary object of study and that the methodology was not designed to pick up differences in symptom patterns. An obvious response to this criticism would be that certain criteria for the disorder must be stated and that it makes sense to keep them as simple as possible. Using the so-called core symptomatology would perhaps be the most culturally neutral approach. However, whatever the rationale for the methodology, the pick-and-choose structure of it should be acknowledged by those who want to draw firm conclusions from the results.

An important finding of the first WHO study was that the outcome for schizophrenic patients in developing countries was significantly better than the outcome for those in developed countries. Building on this finding the WHO then carried out another cross-cultural study called: The determinants of outcome of severe mental disorder project (Sartorius, Jablensky, Korten, Ernberg, Anker, Cooper & Day, 1986). This investigation was even larger than the first, drawing on 12 research centres in 10 countries, and including more than 1300 cases. Results supported the findings of the pilot study, showing similar symptom profiles in all centres. At least, this is the primary conclusion of the initial report, a conclusion which Kleinman (1988) is critical of, considering that some important differences also emerged from the data. For instance, the authors state:

The frequency of the use of individual ICD-9 subtype rubrics varied from 0 to 65% of the cases in the different centres. Overall, paranoid schizophrenia was the most commonly diagnosed subtype followed by that of 'other' (undifferentiated) and acute schizophrenic episodes. However in the developing countries the acute subtype diagnosis was used almost twice as often (in 40% of the cases) as the diagnosis of the paranoid subtype (in 23% of the cases). Catatonic schizophrenia was diagnosed in 10% of the cases in the developing countries but in only a handful of cases in the developed countries. In contrast the hebephrenic subtype was diagnosed in 13% of the patients in the developed countries and in only 4% of the patients in developing countries. (Sartorius et al, 1986: p 16). (Also quoted by Kleinman, 1988).

Whatever the implications of these differences, they deserve as much credence as the data indicating broad similarities. As Kleinman astutely notes, however, in the review by Sartorius et al. they fall in the shadow of universalist conclusions, receiving only a brief mention. Another interesting finding of this WHO investigation was the figures on the annual incidence of schizophrenia across various centres. Two calculations were made according to the results of two different sample groups: one was based on the 'broad' definition of schizophrenia which included almost all the cases in the study and one on the 'restricted' definition based on a computer program classification of a particular subtype of schizophrenia called S+. In order to receive a diagnosis of CATEGO S+ schizophrenia, a patient must exhibit at least one Schneiderian first rank symptom or other unambiguous symptoms typical of schizophrenia, such as auditory hallucination or delusions of persecution.<sup>12</sup> Calculations according to the broad definition yielded incidence rates varying from 1.5 in Aarhus, Denmark to 4.2 in Chandigarh, India. Using the S+ subtype, there was a significantly smaller range of 0.7 in Aarhus to 1.4 in Nottingham (Kleinman, 1988).

Kleinman is critical of the authors' decision to base their conclusions on the narrower diagnostic category which yields quite similar incidence rates across the various populations. The CATEGO program is a narrow diagnostic instrument which is unlikely to be sensitive to subtle cross-cultural incongruence. In fact according to the diagnostic criteria found in the latest DSM, schizophrenia can be diagnosed without the delusional and hallucinatory symptomatology which are considered primary by the CATEGO programme. And moreover, the Schneiderian 'first rank' symptoms of

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<sup>12</sup> CATEGO is a computerised classification program which assigns cases to particular categories according to a set of hierarchical rules.

schizophrenia may also occur in other psychotic states such as affective psychoses (Doran, Breier & Roy, 1986). Kleinman claims, "The restricted sample is artifactual, since it places a clinical template on the original population that excludes precisely those cases that demonstrate the most cultural heterogeneity" (p. 20).

According to Kleinman the broad definitional sample is the appropriate one to work with as it is more true to life; that is, it reflects more accurately the diversity in incidence which occurred in the various centres. The researchers argue that the CATEGO based sample is more appropriate because although it results in a decreased sample size, there is no loss of statistical significance. Interestingly, Chandigarh, India, which was the only rural centre in the study, reported the highest rate of incidence, based on the broad definition of schizophrenia. This would appear to be an important finding, a finding which is lost when the restricted definition is used.

Like the IPSS, the 'Determinants of outcome study' confirmed that the course of the syndrome in patients from less industrialised societies was significantly better than in patients from the industrialised West. The figures supporting this conclusion are rather stunning. 58% of the Nigerian patients and 51% of Indian patients, had a distinct psychotic episode followed by complete recovery, compared to 6% in Denmark and 27% in China. Correspondingly, the rates of chronic psychotic illness ranged from 50% of the patients in Denmark, to 47% in the USA, and 30% in Czechoslovakia and the UK. In contrast the Nigerian sample had only 7% of such cases and the Indian sample 20% (Jablensky & Sartorius, 1988).

It is necessary at this point to discuss the distinction between the disorder and the outcome of the disorder, a distinction which is rather misleading. Whereas the WHO studies seem to differentiate between the manifestation of the 'core' symptoms of schizophrenia and the outcome - which is described at times as if it is a separate entity - the course must be seen as an integral part of the disorder. In the DSM-IV, a clear distinction is made between schizophrenia and brief psychotic episode (which may occur in response to stressful life events). Although these two disorders have very similar 'core' symptoms, the time period associated with each is very different. Essentially, what really distinguishes one from the other is 'course'. So, the finding that

the course of schizophrenia varies across cultures must be seen as a discovery of profound significance, in that 'course' is a defining feature of the disorder.

In conjunction with the 'Determinants of Outcome Study' the WHO also conducted several sub-studies designed to test specific hypotheses. One of these was titled: Stressful life events preceding the acute onset of schizophrenia. (Day, Nielson, Korten, Ernberg, Dube, Gebhart et al., 1987). This study collected data from nine research centres; five in developed countries and four in developing countries, with the goals of:

1. Exploring the feasibility of collecting valid comparative data on the frequency and the kinds of stress provoking events taking place in the lives of psychiatric patients from a wide range of socio-economic and cultural settings; and
2. Cross-culturally testing prior findings in the literature concerning an association between the occurrence of stressful life events and the acute onset of attacks of schizophrenia.

(Day et al, p. 123).

Results showed that methodologies designed to measure the nature and extent of stressful life events in developed countries can be adapted relatively easily to the task of cross-cultural investigation in developing countries. Similar sorts of events were found to be stressful in the various cultural settings and even where stressful events were peculiar to a particular culture it was usually clear to the interviewers, how and why, the particular events would have been experienced as stressful according to the specific context of the events.

With regard to the second aim of the study, it was found that in all research centres a relationship was found between stressful life events and the onset of schizophrenia. However the researchers note that these sorts of stressors are only one of several types of relevant environmental factors which may influence the onset of the disease. They state that "...stressful life events are part of a pool of causal factors found to be associated with the disease" (p. 192). An interesting and unexpected finding of this project was that the onset of schizophrenia in developing countries was more likely to be associated with stressful life events than the onset of the disorder in developed

countries. Relating this finding to the finding of differential outcome would suggest that schizophrenia may be more likely to manifest in developing countries in the form of 'brief psychotic episode'. This disorder, which often occurs after exposure to stressful events, is usually associated with a more rapid and complete recovery. The suggestion here is that the difference in outcomes is due to a difference in mode of onset. Perhaps schizophrenia in the form of brief psychotic episode is more common in developing countries whereas classical schizophrenia is more common in the West.

Commenting on the results of the WHO cross-cultural research programme Jablensky and Sartorius state:

The WHO studies have so far only suggested the possibility that in technologically less complex cultures the chronic deteriorating forms of schizophrenia may be less frequent than in societies imposing on their members complex and potentially conflicting cognitive tasks. We know little about the occurrence and manifestations of schizophrenia in societies radically different from those encompassed by cross-cultural psychiatry up to date, e.g. pre-literate cultures or hunter-gatherer groups. The judicious application of modern research technologies to such settings may give us new insights into the nature of schizophrenia (1988, p. 69).

### *OTHER STUDIES*

A number of studies have investigated differences in the presentation of schizophrenia across ethnic groups in the United States. Several of these have focused on the Hispanic population which comprises the fastest growing ethnic minority (Ruiz, 1995). Looking at psychosis in general, Cuellar (1982) reported that Mexican-American patients exhibit behaviours similar to other patient groups. Looking specifically at schizophrenia, Escobar, Randolph, and Hill (1986) found no major differences in the primary symptoms of the disorder between Hispanic and Anglo veterans. However, Hispanic patients were reported to have a later age at onset, a finding which has also been documented elsewhere (e.g., Ramirez, Johnson, & Opler, 1992). Another interesting difference reported by Ramirez and colleagues was in the presentation of negative symptoms, with Puerto Ricans showing significantly fewer than their Anglo counterparts. In contrast, another study (Dassori, Miller, Velligan, Saldana, & Mahurin, 1993) found that Mexican-Americans exhibited more negative symptomatology.



As noted by Dassori, Miller, and Saldana (1995) these studies, and others in this area, vary with regard to diagnostic criteria and sampling techniques. The criteria for ethnic identification also appear to differ across studies. Some use the term 'Hispanic' loosely and may include participants who are perhaps acculturated. For instance, the majority of the Hispanic individuals in the study by Escobar et al. (1986) were at least second-generation Americans, and moreover, they were from a specific population, namely war veterans. Other studies, for example, Dassori et al. (1993), sampled hospital admissions. It may be variables such as these that underlie the disparities in the results of the above studies. However, notwithstanding the discrepancies, Dassori et al. (1995) in their review of the literature on schizophrenia among Hispanics, concluded that culture influences a number of illness dimensions and that family factors in particular may play an important role in the course of the illness.

Using data from the WHO Determinants of Outcome Study, Susser and Wanderling (1994) investigated the epidemiology across cultures of nonaffective acute remitting psychosis (NARP). They found the incidence of NARP in developing countries to be 10 times that of industrialised countries and propose that such striking epidemiological differences support the view that NARP should be nosologically differentiated from schizophrenia. This epidemiological difference also supports the proposition stated above, that acute psychosis coupled with favourable outcome is more common in developing than developed countries. Another study (Roland & Malanda, 1988) investigating the differences in mental disorders between Africans and Europeans yielded a similar finding, that is, a significantly higher incidence of acute onset, brief psychotic episodes with complete remission, in African patients than in European patients.

An investigation into the presentation of acute psychosis in Egyptians (Okasha, Seif, Dawla, Kahil, & Saad, 1993) found that psychotic symptoms were preceded by a stressor in 74 percent of cases and that the presence of a stressor correlated with positive outcome. The researchers noted that this finding concurs with the general belief that acute psychotic episodes are often precipitated by stressful life events. And they suggest that this etiological variable explains their favourable outcome, meaning that (as commonly believed) psychosis which occurs in response to a stressor will

necessarily have a more benign course. The results of this study have important implications for conclusions drawn from the WHO's research project. As proposed above, the supposed identification of "core" schizophrenic symptoms across cultures may be a misinterpretation of data which is confounded by the presence of patients who are diagnosed as schizophrenic when in fact a diagnosis of brief reactive psychosis would be more accurate (Lin & Kleinman, 1988).

A study looking at the cross-cultural use of the CATEGO S+ diagnostic tool was carried out by Kulhara, Mattoo, Awasthi, and Chandiramani (1987) in India. Like the WHO studies, the Present State Examination was used to interview patients and determine if they met the diagnostic criteria for CATEGO S+ schizophrenia. Comparing their results with previous studies on the cross-cultural manifestation of schizophrenia, including the IPSS, the researchers reported several important differences. In contrast to the pooled data of the IPSS, summarised by Wing, Cooper, and Sartorius (1974), this investigation reported significantly more cases with symptoms of catatonia and more patients experiencing persecutory delusions. Differences were also found when comparing the Indian data with results of a similar study in South Africa (Teggin, Elk, Ben-Arie, & Gills, 1985). The African patients were found to have significantly more symptoms of tension, depression and olfactory hallucinations, while the Indian subjects reported more auditory hallucinations. In contrast to both studies Kulhara et al. found significantly less depressive symptomatology and significantly fewer reports of anxiety and tension. Leff (1973) suggested that these findings may be due to differences in the ability of people to distinguish between various unpleasant emotional experiences. He claims that those from developed countries tend to be better at making these discriminations. Kulhara et al. conclude that "...even in a so precisely defined group of schizophrenics such as CATEGO class S schizophrenia, there are striking cross-cultural differences in psychiatric manifestations," (p. 312).

### *ENVIRONMENTAL VARIABLES*

Murphy and Raman (1971) carried out a twelve year longitudinal study of schizophrenia in Mauritius and reported comparatively favourable outcomes for

patients in contrast to figures on the recovery of patients in Britain. Similarly Waxler (1979) reported significantly better outcomes for schizophrenics in Sri Lanka. In fact Waxler (1977) proposed one of the more well supported explanations for this difference, suggesting that it is primarily due to the expectations of recovery within families and communities. His claim is that in communities where schizophrenia is viewed as an acute disorder there is generally a high expectation that there will be a full, or nearly full recovery. In these sorts of environments, significant others tend to encourage patients' reintegration with normal life and discourage perceiving of individuals as disabled. Chronicity of schizophrenia, is according to Waxler, largely the result of social responses to the patient which exaggerate the long term effects of the condition and undermine the patient's sense of self-control. Kleinman (1988) notes that in the West the course of schizophrenia in many patients is much more positive than the general professional prognosis.

In a study investigating the influence of familial variables on the course of schizophrenia Brown, Birley and Wing (1972) report that schizophrenic patients are particularly affected by excessive emotionality of family members and they suggest that this can act as a stressor, perpetuating the illness and perhaps even precipitating it. Other more general stressors have also been implicated in the disease; such as bereavement, unsupportive relationships and difficult children (Sheldon, 1994). Focusing on the influence of family life on schizophrenia Jenkins, Karno, De La Selva and Santana (1986) measured and compared amounts of expressed emotion (EE) in Mexican-American and Anglo-American families of schizophrenic patients. EE refers to the family's amount of criticality and overinvolvement with the relative with schizophrenia.<sup>13</sup> Jenkins et al. found that in contrast to their Anglo counterparts Mexican-Americans were significantly less likely to be classified as high EE. And concurrently they showed that Mexican-American patients were less likely to relapse during follow-up. Other researchers have reported similar findings in comparing Western and non-Western families of schizophrenics (e.g. Karno, Jenkins, De La Selva, Santana, Telles, Lopez & Mintz, 1987; Leff, Wig, Ghosh, Bedi, Menon & Kuipers et al., 1987).

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<sup>13</sup> A detailed account of the EE concept and its use in the study of schizophrenia and family functioning is provided by Jenkins (1991).

It has been suggested that EE may reflect aspects of social support (Lin & Kleinman, 1988). Many non-Western peoples live in the context of an extended family which may perhaps provide a more supportive environment to the recovering schizophrenic. Care of the schizophrenic family member is less likely to become the responsibility of one particular relative - such responsibility may be shared, meaning that the illness does not impact so intensely on any one person. Also, in an extended family, simple logistics would imply that the patient will be more likely to find support and understanding within their own home. EE is just one of many socio-cultural variables which may impact on the manifestation of schizophrenia. There are many others, although typically they are difficult to measure. EE has received a considerable amount of attention in the literature because of its conduciveness to cross-cultural investigation and perhaps because it attempts to shed light on the issue of differential course and outcome of schizophrenia.

Dassori et al. (1995) write: "The differences in course of schizophrenia among countries are particularly intriguing. They suggest a powerful influence of environmental factors..." (p. 304). However they also draw attention to the more original point that environmental factors are not always purely social. They refer to a study by Mendoza, Smith, Polan, Lin and Strickland (1991) which reports differences in neuroleptic dosage requirements between some ethnic groups.<sup>14</sup> The authors of this study suggested that differences were due to factors such as diet, alcohol consumption and exposure to toxins which they propose could affect physiological responses to neuroleptics. Considering environmental variability world-wide this proposition is profoundly relevant to cross-cultural research on mental disorders.

## SUMMARY

In summary, the conceptual and methodological limitations of studies investigating schizophrenia cross-culturally preclude the drawing of firm conclusions. While the WHO research programme has made a significant contribution to the understanding of schizophrenia across cultures, its results must be interpreted cautiously because of the Western-focused nature of its methodology. It sought to affirm the universality of

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<sup>14</sup> The differences related to immigrant status not to ethnicity per se.

schizophrenia across people and followed an investigative method which was arguably weighted in this direction. Even so, these research projects represent an impressive achievement and have resulted in the detection of some important phenomena. The difference in course across cultures raises the question of whether the psychosis identified in various populations was in fact schizophrenia, some variant of the spectrum, or another psychotic disorder altogether.

It is highly likely that psychosis of one sort or another is ubiquitous in humanity, however psychosis as delineated by the concept of schizophrenia may not be. Evidence suggests that it is a condition which may be importantly influenced by socio-environmental factors. Clearly, more research is needed in order to illuminate the intricacies of the relationship between social and psychological variables and the various ways in which schizophrenia may be influenced by culture.

# *PART THREE*

## *A CONSTRUCTIVIST APPROACH TO THE UNDERSTANDING OF MENTAL DISORDER*

## CHAPTER 7

# THE HISTORICAL DEVELOPMENT OF CONSTRUCTIVISM

This chapter introduces constructivism through an examination of its historical beginnings and its subsequent development over the last two hundred years. Drawing heavily on Mahoney's (1988) historical analysis of constructivism, theorists who contributed to its evolution during this period are introduced chronologically. It is important to note that most of these philosophers are described broadly as constructivist, retrospectively. In their respective times they would not have been adhering to or supporting a philosophy with this name. Rather, what they all have in common is a particular theoretical position which is today construed as consistent with constructivism and which can therefore be understood as contributing to it.

The chapter is comprised of two sections. The first is a historical exegesis which covers a variety of key figures discussing the pertinent ideas of each, while the second section examines in detail the work of two significant contemporary constructivists.

### FROM VICO TO KELLY

Mahoney (1988a) traces the beginnings of 'constructivist thinking' to Giambattista Vico, an 18th Century philosopher. Although best known for his contribution to the philosophy of history, Vico was also interested in human mental processes. In response and in contrast to Cartesian dualism, Vico recognised the connection between 'thought and extension'. Descartes' view which was reminiscent of early Greek philosophy, was dominated by the claim that 'thought' is independent of 'matter'. This echoes the Platonic idea that 'intellect' is separate from, and superior to the physical world. The well known empiricists Locke, Berkeley and Hume who were contemporaries of Vico,

rejected this view and claimed instead, that all knowledge arises out of direct 'sensory' experience with the physical realm; that knowledge is inextricably linked to the subject matter which it describes. It was in this conceptual atmosphere, namely the emergence of empiricism, that Vico discussed human mentality.

Although there are some empiricist influences in Vico's work, his ideas were characterised by an emphasis on the *process* of knowledge acquisition as opposed to the simple data of sense experience. On the one hand he acknowledged that human thought arises out of environmental demands; that it responds to and interacts with the world around us. On the other hand he saw the mind not as a passive participant which directly apprehends the world, but rather as a complex and active processor of life events (Verene, 1981). He realised the significance of symbolism and language in human evolution and emphasised their role in scientific understanding. In contrast to the empiricist view, Vico asserted that truth is largely dependant on experiential and social variables and challenged the popular view (of the time) that it could come about only through direct apprehension of the world.

The next major contributor to the beginnings of constructivism was Immanuel Kant, another 18th Century writer. Like Vico, Kant's approach to epistemology was centred around the notion of active cognition. However: "While agreeing that all knowledge *begins* with experience, he challenged the idea that all knowledge is *based* in experience," (Mahoney, 1988a, p. 21). He developed the concept of 'a priori knowledge' for which he is most well known. This is knowledge which is generated by logic and which requires no empirical justification. But what is most pertinent to this discussion is his emphasis on the role of the mind in epistemological matters. The mind is understood by Kant, to be the touchstone and primary progenitor of truth. (The mind in this case is essentially a synonym for thought, or more precisely rational thought). This is in stark contrast to empiricist thinking which has the external world as its epistemological focus.

Kant's appeal to rationality as the source of all truth, conjures up images of Platonic forms, however there is one major difference. Kant made no corresponding theological claims. Whereas Plato equated the intellect with a 'higher good', Kant imposes no outside order on the human mind. Kant does however state that the 'idea' of God may



provide some sort of self-imposed order or constraint on ideas, but this is only for convenience; primarily as an aid for morality, and should not be interpreted as a reflection of his ontological views (Durant & Durant, 1967).

According to Mahoney (1988), Kant's philosophy was influential in the work of Hans Vaihinger (1852-1933) who was the first to elaborate on, and formalise some of the early constructivist ideas. Vaihinger states:

Consciousness is not to be compared to a mere passive mirror, which reflects rays according to purely physical laws, but "consciousness receives no external stimulus without moulding it according to its own nature." The psyche then is *an organic formative force*, which independently changes what has been appropriated, and can adapt foreign elements to its own requirements as easily as it adapts itself to what is new. The mind is not merely appropriative, it is also assimilative and constructive. (Cited in Mahoney 1988a, p. 24).

Clearly expressed in this passage is the interpretative role of thought. Vaihinger asserts that the mind processes information and that in doing so, changes it. Hence it can never provide a perfect representation of an objective reality. Vaihinger sees this not as an inadequacy, but rather as an inevitability, the utility of which is measured in terms of its contribution to an organism's survival. For Vaihinger the mind's function is primarily adaptive. The ability to consciously reflect on and evaluate external stimuli allows a greater variety of responses. This is in contrast to the reflexive style behaviours of less complex organisms. So, the mind allows more effective negotiation of the world and does this by processing and assimilating information and creating an abstraction. While the abstraction, is by definition imperfect, it may none-the-less be useful. It is important to note that although most constructivists agree that the physical realm is not directly accessible (at least not without some amount of reconstruction), it is not therefore *only* a mental figment. Vaihinger would say that there is an external world, however discussions about that world may not actually be based on information which is attained directly from it. Rather such discussion may arise from ideas, about impressions, about interpretations, etc. about the world.

Critics of constructivism no doubt abhor this scepticism. Knowledge inevitably becomes a 'fiction', in the sense that it is a concocted narrative. And this interestingly,

was Vaihinger's primary interest. In stark contrast to Kant's focus on the notion of *a priori* truth, Vaihinger discusses at length, the role of fiction in science and philosophy. He uses this term (fiction) to explain how ideas change over time and why there is often resistance to such change. Narratives become familiar and there is comfort in familiarity. When the world is interpreted according to particular beliefs, it may be difficult to change those beliefs when so much is dependant (or seemingly dependant) on them. In reply to the sceptics, Vaihinger would emphasise the value of constructive knowing. A person can bring his or her own experience to bear on a situation and interpret it according to what has been previously learnt. If human mental processing was passive and unintrusive, this sort of intelligent response would not be possible. While objective reality may appear to anti-constructivists to be the sacrificial lamb, it may none-the-less contribute to the greater good, if good is measured in terms of adaptive success.

Within psychology, the leading constructivist this century has been Jean Piaget. Like Vaihinger, Piaget rejects the view of empiricists, that the mind is passive and simply reflects external stimuli (Piaget, 1970). Rather he talks about assimilation and accommodation and how cognition involves these 'active' processes in learning and knowledge acquisition. Assimilation refers to the ongoing cognitive ingestion of experiential data whereby data are integrated into existing cognitive structures. Accommodation, on the other hand, refers to structural change which occurs in response to novel stimuli, meaning that mind mutates in accordance with the demands of new experience. Lyddon and McLaughlin (1992) state:

...the role of experience within the Piagetian perspective is not to dictate the form of knowledge, but rather to create disequilibrium - a disequilibrium that challenges the knower to actively construct novel forms of understanding (p. 98).

This view suggests a dynamic interplay between the individual and the environment which affords a versatile and adaptive cognitive life. And most importantly it asserts the role of 'construction' in human understanding. Piaget's primary focus is learning and development. However his work is clearly reminiscent of early constructivist philosophers whose concerns were confined to broader theoretical topics. In terms of

epistemology, Piaget obviously assumes a relativistic view wherein knowledge is constrained by but not confined to, the external world.

Another relevant and influential thinker early in this century was John Dewey (1859-1952). Dewey commented on a wide range of topics and advanced a proliferation of original ideas. In one of his early essays he wrote:

From the psychological standpoint the relation of Subject and Object is one which exists within consciousness. And its nature or meaning must be determined by an examination of consciousness itself. The duty of the psychologist is to show how it arises for consciousness. Put from the positive side, he must point out how consciousness differentiates itself so as to give rise to the existence within, that is for, itself of subject and object. This operation fixes the nature of the two (for they have no nature aside from their relation in consciousness), and at the same time explicates or develops the nature of consciousness itself. In this case it reveals that consciousness is precisely the unity of subject and object (from McDermott, Ed., 1973, p. 106).

For Dewey, there can be no knowledge without a knower. Like Piaget knowledge is viewed as dependant on the process through which it arises and this necessarily involves some sort of transformation. The following excerpt expresses more precisely the interdependence of the internal and the external:

The nervous organism, the objects, the series of events *as known*, are relative to our consciousness, but since this itself is dependant, is a product, there is a reality behind the processes, behind our consciousness, which has produced them both (from McDermott, Ed., 1973, p. 107).

This is consistent with Piaget's notion of active cognition and the circular relationship between the thinker and the object (or perhaps the perceived object) of thought. The way that the organism interprets events is mediated by both inner structure and external reality. What is known is relative to consciousness and consciousness itself is influenced by its own previous manifestations and external information. But here Dewey departs from Piaget, claiming that although the evaluation of experience is mutative, in that it involves a step back from reality and a step towards construction, there is however such a thing as 'brute' experience. For instance the sensation of pain, or the perception of a colour. He says that these sorts of experiences are not "a matter

of knowledge” but of “existence”. That is to say, a sensation just *is* whether or not one chooses to interpret it or describe it.

However Dewey can still be described as a constructivist. He states: “To know a quality *as* sensation is to have performed an act of complicated objective reference; it is not to register an inherently given property” (from Pepper, 1942, p. 29). Dewey’s point is that regardless of one’s intellectual acts there will be certain objects of analysis. To use Dewey’s example: Whether or not what one sees is actually a red tomato, one cannot doubt that there is in one’s visual field an object that looks red and is the shape of an ordinary tomato. However despite the indubitability of the red object, as soon as it is called a tomato and subsequently eaten, a constructive operation has occurred. For Dewey, the fact that there are hard data does not in any way diminish the constructive role of cognition. Although there are objects, knowledge of them does not arise through direct apprehension, but rather through a combination of perception and cognition.

Around the time that Dewey’s career was drawing to a close, Stephen Pepper published a book entitled ‘World Hypotheses’ (1942). In it he presented an interesting and rather innovative approach to the understanding of various world views. He termed these world views ‘root metaphors’ and claimed that these lie at the heart of many more complex metaphysical theories. Basically, he outlined four different modes of understanding: formism, mechanism, organicism and contextualism. In short, the difference between these approaches is the underlying or perhaps overriding metaphor.

For formism this metaphor is similarity. Data are assigned to various categories according to their similarity to ideal forms. This involves a process of typification wherein phenomena are categorised in relation to their material and stable essences. Mechanism, on the other hand, is based on the root metaphor of the machine and construes the world in terms of discrete yet interactive parts. This view assumes that there are linear cause and effect relationships between stable entities. In contrast, organicism, with its focus on living systems, presents a more dynamic picture. According to this view, phenomena are in an ongoing process of development and transformation. This development is goal directed; that is, it is the result of inherent ‘growth oriented’ natures. Finally, contextualism uses the root metaphor of the

'historical event' and explains with reference to context. By 'historical', Pepper means not an event that occurred in the past, but rather a present event within a context of various other interwoven events. Unlike organicism, this view assumes an open-endedness claiming that basically, anything can happen. This is illustrated by the following excerpt:

Contextualism is accordingly sometimes said to have a horizontal cosmology in contrast to other views, which have a vertical cosmology. There is no top nor bottom to the contextualistic world. In formism or mechanism or organicism one has only to analyse in certain specified ways and one is bound, so it is believed, ultimately to get to the bottom of things or the top of things. Contextualism justifies no such faith. There is no cosmological mode of analysis that guarantees the whole truth or an arrival at the ultimate nature of things. On the other hand, one does not need to hunt for a distant cosmological truth, since every present event gives it as fully as it can be given.

(Pepper, 1942, p. 251)

This view exhibits a conspicuous lack of determinism, realising that as phenomena emerge, they give rise to new phenomena, and that events are inextricably linked. Hence, in a sense there is no touchstone of truth other than the complex pattern of active ongoing acts which are embedded in context. According to this system of understanding, one can not accurately describe a thing or process without reference to its interdependent variables as these become part of the thing itself.

Relatedly, Mead (1934) offered the term 'emergence' to refer to features which arise through the interaction of organism and environment (Prawat & Floden, 1994). This is rather like the Gestalt idea that a whole is greater than its constituent parts. According to the Gestalt view a whole has qualities which are not present within individual components; rather something quite new can emerge from the relationship (Wertheimer, 1922). Hence, the study of the parts of a phenomenon will not necessarily lead to greater understanding of that phenomenon. What is important is the interaction of the parts and the properties which arise as a result of it. And this is also what Mead's term 'emergence' expresses.

Pepper's contextualism embodies these ideas. Phenomena must be viewed in context. If for example one intends to analyse human behaviour, the analysis must include the

environment, particularly the social environment. The essential point, and one which is also central to a constructivist epistemology, is that knowledge can not be gained from the intensive study of isolated phenomena. Rather, phenomena must be studied in relation to their various interconnections with one another and to their context. In the field of psychology such an approach is particularly valuable, as human behaviour is comprised of a complex mixture of variables and a thorough understanding will depend on the acknowledgement of all of these. More generally, Pepper's description of several alternative world views is also relevant. This is compatible with the broad constructivist assumption that different constructions may each offer their own unique and valuable perspective. This is in contrast to rationalist theories which seek to explain with reference to only one system and which strive for a single 'truth'.

Finally to end this look at the history of constructivism, is a brief introduction to the most important figure in constructivist psychology. Described by Mahoney as the 'pioneer constructivist' (in the fields of personality theory and psychotherapy), George Kelly was the first person to apply constructivism specifically to psychological topics. Although several theorists such as Piaget and Dewey had previously discussed the 'mind' in light of constructivist ideas, such discussions were largely philosophical in nature. Kelly brought constructivism fairly and squarely into the domain of psychology. This is not surprising considering that he worked as a clinician for 25 years before publishing his first major work, "The psychology of personal constructs," (Stewart & Barry, 1991).

In this Kelly claims that although there is a single, external world, there may be many different ways to conceive of it. This position has been called *alternativism* as it views knowledge as a matter of alternatives. The *alternativism* is based on the assumption that the world is not directly perceived, but rather, is represented to (and processed by) individuals in various ways depending on their own unique construct systems (Kelly, 1955). Like *Vaihinger*, Kelly asserts that perception involves a process of abstraction, whereby people construct their representations of the world, but going one step further, Kelly focuses on the concept of alternatives and asks the question of why one abstraction is chosen over another. This point is illustrated in the excerpts below:

A full-fledged psychological inquiry into the behaviour of a baby, for example, is not confined to calculating what he will pop into his mouth next, nor to training him to do what we want by frustrating all his ingenious efforts to escape the strictures we have imposed, but invites us to look at him and wonder what vast and unforeseen alternatives might lie ahead (Maher, Ed., 1969, p. 8).

Kelly assumes that information about alternatives comes from context. An understanding of the context and an understanding of the alternatives, go hand-in-hand. This is very close to Pepper's contextualism. Kelly states:

Construct theory, or better, *personal construct theory* - a term which implies that a construct is as much a personal undertaking as it is a disembodied scheme for putting nature in its place - suggests that human behaviour is to be understood in a context of relevance (Maher, Ed., 1969, p. 11-12).

So, objects, phenomena and human behaviour, or any other item of scientific inquiry cannot be explained without reference to context, and the alternatives which arise from it. According to Kelly there are many different ways of construing the world, however we are constrained by our personal experience and our social environment, both of which shape our construct systems. For instance language is perhaps our most significant construct system. We view and interpret the world in terms of this system. And this interpretation is not a passive response; rather it involves an active process of selecting information which is considered relevant and comprehending it according to the concepts which we are familiar with. A major influence on Kelly's constructivism was Jacob Korzybsky (1933, 1943), who claimed that human beings' interaction with the world is mediated by linguistic referents (Stewart and Barry, 1991). Like other constructivists, Korzybsky was interested in the process of abstraction, which was used to denote the activity of apprehending selected environmental stimuli. He suggested that psychological problems arise largely from a break-down of the process of abstraction, which causes the disruption of a person's ability to evaluate and understand his or her environment. Kelly agreed with this view, stating that mental health is dependant on the cognitive and linguistic constructs which people employ in their interaction with the world.

As mentioned, Kelly's Personal Construct Theory was presented after many years of practice as a clinician, and hence while it seems to involve some rather abstract claims,

it has a strong pragmatic focus. The theory was fostered in conjunction with developments in his therapeutic techniques. The central tenet of Kelly's thinking during this time was the merit and utility of alternativism. This necessarily suggests choice and the opportunity for change, which Kelly considered vital to the treatment of psychological disorders. The fact that construct systems can be changed provides a therapeutic window. A person who is using a conceptual map which is ineffective or debilitating can change it and bring about improvement in their quality of life. This claim may seem unclear and far-fetched. How can a change in mere terminology attend to the difficulties of mental disorder? For Kelly, a construct system is not just terminology; rather it is a deeply embedded aspect of personality which affects every dimension of a person's existence. It influences how we see ourselves in relation to the world and this is fundamental.

Kelly saw drama as an effective means for eliciting change. Building on the work of Jacob Moreno who was one of the first major psychodramatists, Kelly experimented with the use of role-playing as a way of enabling people to develop newer and better construct systems. Moreno (1937) claimed to have observed substantial improvement in patients who participated in his psychodramatic programme. Kelly particularly liked Moreno's use of spontaneous improvisation which encouraged people to lose their inhibitions and challenge their self and world-perceptions. One important goal of this dramatic method is to allow the expression of hidden aspects of personality. It was Kelly's view that many of his patients had hidden potential and role-playing was seen as one way of encouraging this potential to emerge. Kelly believed that in this way people would be better placed to understand their problems and find solutions.

Kelly's constructivism is refreshingly optimistic in contrast to the cynicism of some early constructivists, who saw human knowledge as trapped within the lonely bounds of relativism. Kelly seized the creativity of constructivism and used it as the basis of his therapeutic method. For him, the relativity is an expression of the mutability of knowledge and the fact that epistemology is directed toward human ends. These ends are dependant on the interaction of human beings and their environments which is mediated by personal and social construct systems. This view, namely the significance of personal and social constructions and their role in the understanding of psychopathology will play a key role in forthcoming discussions.



## CONTEMPORARY CONSTRUCTIVISTS

Within psychology and particularly its application in psychotherapy, the two most influential constructivists are Robert Neimeyer and Michael Mahoney. Both are psychotherapists who use a constructivist approach in their clinical work and like Kelly, stress the advantages offered by this particular construal of human thought and behaviour. And both display a clear understanding of constructivism's philosophical claims. The term 'philosophical' is used here to indicate the theoretical or perhaps abstract aspects of constructivism which form the foundation of its use within psychology. This must be distinguished from the use of the term constructivism within philosophy, where its meaning may be quite different. It has been used as a synonym for 'rationalist interventionism' which describes a particular approach to the regulation and control of complex open systems. And within mathematics it denotes an epistemological position which claims, that in order for mathematical statements to be true, they must be supported by formal proof (Mahoney, 1988a). The definition of constructivism which is being used herein, has in part been outlined by the overview of the various pertinent thinkers of the last few centuries. The brief introduction to the work of Neimeyer and Mahoney, that follows, is provided for two reasons. Firstly, to bring the historical analysis up to date, and secondly to elaborate on the earlier ideas and hence complete the definition of constructivism.

### *Robert Neimeyer*

Neimeyer contrasts the constructivist 'movement' with traditional cognitive therapies which have their roots in logical empiricist and rationalist ideologies (Neimeyer, 1993a). These ideologies promote the view that logic (or rationality) is the basis for knowledge, and that it provides one all encompassing framework within which all knowledge arises. It is the method and test of truth, and has a transcendental aspect to it which enables the knower to overcome problems of relativism. Tied to this, is the idea that there is a real world which can be directly apprehended and that truth corresponds to this real world. So according to this view, knowledge is both logical and empirical; it involves both reason and observation. With regard to psychopathology this view

assumes that effective treatment must involve the substitution of rational for irrational cognitions.

As noted by Neimeyer, constructivism presents a very different view, representing an extensive shift in metatheoretical thinking. He sees this as part of the 'post-modern' era which places more significance on the constructive or perhaps 'constructed' aspects of knowledge and awareness. He states:

Perhaps the core of post-modern consciousness is the increasingly widespread awareness that the belief systems and apparent 'realities' one indwells are socially constituted rather than 'given,' and hence can be constituted very differently in various cultures (or subcultures), times, and circumstances, although they might appear to carry the force of necessity to those who inhabit them (1993a, p. 221).

As succinctly stated by Neimeyer, the post-modern view challenges logical empiricism's core proposition: that knowledge objectively represents an all-encompassing external reality and that it also expresses certain indubitable laws; like Einstein's theory of relativity. According to the constructivist, the theory of relativity is *one* way, not *the* way of understanding a phenomenon. Placing this view in the context of the present discussion yields a progressive vision of mental disorder across cultures. Progressive, because it reflects the growing acceptance and appreciation of cultural diversity throughout the Western world. What is being alluded to, is a view which is very different to the typical universalist approach which dominates Western psychology. Whether or not mental disorders are largely, or at least to some extent, culture-bound, this view asserts that a classification system such as the DSM-IV is *one* way of understanding them. There may be other equally effective systems, because as Neimeyer states these systems are not 'given', but rather, 'socially constituted.'

Of course Neimeyer is speaking generally about knowledge, not about mental disorder, however he does make some comments about the latter. He discusses the differences between traditional cognitive therapies and constructivist therapies, which rest on quite incompatible construals of psychological disturbance. Cognitive therapies such as those espoused by Beck and Ellis, aim to promote rationality, and encourage individuals to perceive things as they 'really' are. According to this therapeutic approach, mental

disorders are primarily due to faulty or illogical thinking which does not correspond to the world. Neimeyer argues, along with Anderson (1990), that 'in a world with many realities' this construal of mental disturbance is very difficult to uphold. There are numerous languages, religions, customs or whatever, hence they ask the question: How can maladjustment to one, be the one and only hallmark of ill health? This is an important question which clearly challenges objectivists. If there is only one true understanding, one must choose which is correct and this will necessarily render the others wrong. This sort of absolutism is an unfortunate consequence of the rationalist's quest for objectivity. Strangely, many religions rely on this sort of reasoning. In order for them to be right, all other religions must be wrong and if they are right, then all others are sure to be wrong. Yet, of course they all believe that they are right, because they all lay claim to a 'true' perception of the world.

Neimeyer states that rather than the outright rejection of inaccurate cognitions, constructivists maintain that:

...the viability of any given construction is a function of its consequences for the individual or group that provisionally adopts it, as well as its overall coherence with the larger system of personally or socially held beliefs into which it is incorporated (1993a, p. 222).

This is reminiscent of Vaihinger who saw the value of personal constructions and acknowledged their adaptive qualities. What is important is whether or not an idea 'works' not whether or not it 'fits.' Obviously many ideas which are good ( in terms of their contribution to an organism's survival) will do both (therefore *fit* and *work*) however Neimeyer suggests that sometimes a belief may have positive consequences without being a true representation of the world. Note the mention of and hence distinction between, personal and social systems of knowledge. There will inevitably be differences between these however both are important for constructivism. Neimeyer states:

At the core of constructivist theory is a view of human beings as active agents who individually and collectively, co-constitute the meaning of their experiential world...From this perspective, human knowledge is ultimately (inter)personal and evolutionary, with no simple prospect of

validation against an objective reality beyond peoples constructions (1993a, p.222).

So, meaning occurs at both the level of the individual and the community. In a sense, the individual is a sub-culture, and the immediate family is a wider sub-culture and the community an even wider sub-culture and so on. While meaning is construed in terms of social norms and expectations, it is also tested against ones own unique set of experiences. And what matters to the constructivist is not the external validation of meaning, but rather how that meaning enables people to live their lives.

According to Neimeyer, the constructivist approach to psychotherapy is based on this philosophy. Rather than attempting to change a person's 'faulty' cognitions, constructivist therapy attempts to facilitate change *within* the patient's own unique construct system. As Neimeyer states, the goal is 'creative' rather than 'corrective', in that beliefs are viewed as fundamentally positive and as part of an intricate pattern of ideas which, ideal or not, has been of some use to the person. Therapy is flexible in that it is tailored to individual needs; it acknowledges differences in customs and culture and responds to the particular needs of the client. As a therapeutic approach this may seem rather vague, however it should be noted that Neimeyer is speaking generally about a broad field which is comprised of many quite different therapeutic techniques. As a theoretical movement within psychology, constructivism lends itself to a variety of conceptualisations of psychopathology and a number of treatment methods, all of which express a similar philosophy of mind.

As noted by Neimeyer, Kelly was the first to systematically use constructivist ideas in clinical practice. He experimented with role-playing techniques wherein clients were encouraged to try out different construct systems. Most importantly, he realised the consequence of language and other social tools which shape and in a sense limit peoples cognitions. This awareness contributed to a dynamic and colourful clinical method which promoted the self-examination of beliefs, desires and meanings, hence creating the opportunity for modification.

Relatedly, another type of therapy listed by Neimeyer, which relies on constructivist principles is narrative reconstruction. As its name suggests, this psychotherapeutic

method assumes that people live, and make sense of, their lives through stories. A literary explication is used as a metaphor for the client's life and a therapeutic tool. An understanding of the story gives insight into its direction and deficiencies, and stories can then be retold. What is most important is 'meaning', as opposed to actual events, because events occur within a context and are interpreted and experienced according to peoples' inner narratives.

Because of the strong focus on context and social variables, of constructivist approaches to the treatment of psychopathology, they are particularly useful in the field of family therapy. And this has become a primary area of their use. Therapists of this method pay special attention to relationships between family members and the family's unique style and system of interaction. An important goal of the therapist in this situation, is to promote the idea that there may be different yet compatible perceptions and opinions within a family, and to encourage family members to try out various scenarios, particularly those of, say, their siblings. This is aimed at promoting acceptance and a heightened understanding of each other.

An important closing remark which Neimeyer makes in his article on constructivist therapies, is that the therapist does not claim to have greater authority or knowledge, than the client. The relationship is one of equality and co-operation and the client and therapist work together as 'co-investigators', studying construct systems and where necessary, challenging them. This is in stark contrast perhaps, to traditional clinical psychology which seeks to understand by imposing its own system of analysis on clients who have very little understanding of it. The intention herein is to apply constructivist ideas to this more strict and implacable field, by way of a critique of its properties and theoretical foundations. Although as mentioned by Neimeyer, constructivism and its applications are becoming increasingly popular within psychology, this approval is limited largely to the area of psychotherapy.

Arguably, Neimeyer's account of constructivism can be criticised for being too strongly relativistic. He seems to stress the social context of knowledge to the exclusion of material phenomena. While his ontological views are not entirely clear, he explicitly states that the external validation of meaning is irrelevant. What *is* considered relevant, is the extent to which individuals' understandings of experiences enable them to live

their lives. But supposedly there is some overlap here. It is undoubtedly advantageous to understand that serious injury may result if one steps into the path of an oncoming vehicle. Clearly, in many instances, there is what may be termed a correct interpretation of events which has little to do with socio-cultural factors. And in such cases hard data may provide confirmation of ideas and theories and hence a contribution to knowledge. In explicating the role of meaning in human experience, Neimeyer, like Vaihinger, relies on the notion of utility, claiming that the meaning that one ascribes to events should prove useful – in other words it should assist the individual in some way. However Neimeyer fails to acknowledge that the external world places certain constraints on the process of ascribing meaning, thereby delimiting what may or may not be a useful interpretation.

Relatedly, in discussing psychotherapy, Neimeyer suggests that the therapist should attempt to effect change within the client's own unique construct system. In contrast to the approach of traditional cognitive therapy, Neimeyer proposes that it is inappropriate to set out to 'correct' the 'faulty' cognitions of the client because the therapist's role is not one of a 'judge' but of an 'equal.' According to this view the therapist has no right to impose on the client, his or her perception of what is suitable thinking, because it is no more likely to be right than the client's. This view is clearly problematic because it puts the therapist in a position of complete inaction. At every turn the clinician must decide how to best help the client and to do this he or she must rely on a combination of personal experience and professional skills. If the clinician fails to impose these on the client in any way then it is likely that there has been no therapeutic process. Moreover, in many situations, progress in therapy is dependant upon the client being challenged in some way. This encourages experimentation with alternative ways of thinking, feeling and being, which may not be discovered otherwise. One must not forget that a primary purpose of therapy is personal change and personal growth.

### *Michael Mahoney*

Michael Mahoney is one of the most prolific writers on the subject of constructivism and psychology. Like Neimeyer his key area of interest is psychotherapy, however he has also provided a detailed analysis of 'constructive metatheory', which is, "...a

family of models and theories that share the foundational assumption of *constructivism*” (Mahoney 1988a, p. 1). Mahoney views constructivism as a powerful and broad philosophical movement which has emerged slowly and in various forms over an extended period of time. He insightfully acknowledges that constructivism can trace its conceptual lineage to both idealism and realism which are of course mutually incompatible theories. For example Kant was clearly an idealist; he claimed that the objects of our experience do not exist independently of our thoughts. Whereas theorists such as Vaihinger and Dewey admitted to the actual manifestation of matter, independent of mind. These two dichotomous views have been called radical constructivism and critical constructivism (respectively).

Radical constructivism is indistinguishable from idealism in that it claims that knowledge is simply an expression of human beings’ capacity to organise and process experiences; experiences which have no correlation to a ‘real’ external world (von Glaserfeld, 1984; Varela, 1979). In contrast, critical constructivism takes a compatibilist approach, proposing that although knowledge is constructed, its constructions are constrained by external determinants (Weimer, 1979). As Mahoney points out, like him, most contemporary constructivists are critical constructivists. They acknowledge the existence of the material dimension, however they claim that access to it can only be partial and indirect.

In his summary of the primary elements of ‘constructive metatheories,’ Mahoney states that they:

1. acknowledge the power of ideas and mental/symbolic processes that mediate, constrain, and order the particulars and patterns of experience.
2. acknowledge the existence of a ‘real’ external world – “the furniture of the universe” - that can be known to us only individually and imperfectly.
3. acknowledge the potential power of reason and rationality in human knowing, that power being most apparent when it is applied in the service of critical (disconfirmatory) examination rather than positive confirmatory justification; and
4. assert that the function of data (sense and scientific) in knowledge development is essentially one of selecting or winnowing enacted hypotheses; in this sense, data do not justify or form the foundations of

*valid* knowledge, but instead selectively eliminate less viable approximations.  
(Mahoney, 1988a, p. 4-5)

This delineation is a confluence of many of the ideas which have already been expressed in this chapter: That the world can only be known indirectly, because the mind actively and 'constructively' processes information; that knowledge should be 'viable' as opposed to 'valid' because it arises within a complex system of ideas which enables negotiation of the world. In this sense knowledge is relative to individuals and communities. These milieus provide their own validation; hence there is no need for an objective evaluation. Another important factor is criticality which refers to the process of actively examining information and evaluating it according to reason and to individual beliefs and needs. The suggestion here is that in the process of applying reason to a situation, people will draw on their past experiences and particular construct systems; for instance their languages. They may also consider their goals in the analysis of information.

To describe another facet of constructivism, Mahoney introduces the term 'morphogenic nuclear structure', which he claims captures the fundamental nature of human mentality. This fundamental nature involves a central core around which more peripheral structures and processes are organised. Mahoney states that peripheral activity is also constrained by the central system. To exemplify this idea, he draws on the field of linguistics. Chomsky used a distinction between deep structure and surface structure in his understanding of language. The deep structure consists of abstract organising rules which shape and delineate expressions at higher (as in nearer to the surface) levels. The central point is that the abstract rules determine the nature of the peripheral linguistic expressions and that this process is often covert. In other words the power of abstract and underlying linguistic mechanisms and tools is often underestimated or even overlooked.

According to Mahoney, another position with a component which is similar to the concept of 'morphogenic nuclear structure' is that of Hayek, who uses the term 'unconscious' where Chomsky would use deep structure. As noted by Mahoney, the meaning which Hayek ascribes to the notion 'unconscious' is very different from



Freud's use of the term. For Hayek an unconscious process is simply a process of which a person is not conscious (Hayek, 1978). It is not therefore 'sub-conscious' but rather, more likely, 'superconscious' because it has an enormous influence on a person's experience of the world. Hayek's unconscious is like Chomsky's deep structure in that it orders and constrains conscious processes. Although the unconscious consists of, or is a product of, abstractions and generalisations, it impacts on and delineates the 'particulars' of experience. It is form-giving; it guides perception and interpretation although it is not impervious to influences from above (or perhaps below). The abstracts are of course affected and modified by the particulars.

Another feature of constructivism described by Mahoney concerns the private or personal focus of the term. Experiences and the meanings which are ascribed to them are essentially private. For instance unconscious or abstract processes will differ significantly across individuals even though the individuals may share the same language and similar environment. Because psychological phenomena revolve around the self, which is of course unique. The individual is the centre of his or her universe and life experiences are understood relative to this vantage point. There is an on-going quest for survival and prosperity which is inevitably self-centred. And this self-centredness dramatically affects one's existence. It is all-pervading and hence influences, though often implicitly, one's experience of the world. According to this view the self and its goals provide a touchstone for knowledge development. Theories which promote survival and success are more likely to become a permanent part of the person's belief system.

This idea can be illuminated through a comparison with evolutionary theory. Like animal adaptation, theories are exposed to pressures which may cause them to mutate or die (or carry on unchanged). The pressures in this case are criticism and refutation, but though the purpose of these pressures is to reveal the 'truth', what they actually do is eliminate the least viable theories. Success of a species is measured in terms of its success in a particular environment. If it is taken out of that environment it may become extinct. And a species which thrives in its own unique habitat may yet become extinct; it is not therefore immune to danger. Likewise a theory may be useful at one time and useless at another or it may have to be modified according to changes in the larger metatheoretical picture.

What survives is not necessarily right, but it has not been shown to be wrong. Karl Popper is well known for his falsificationist construal of knowledge development, which claims that general scientific theories can be falsified but not verified (Popper, 1972). In fact he claimed that falsification is the hallmark of science. His famous illustration of this point uses the statement, "All crows are black". Popper claims that no amount of observation will verify the proposition however the observation of a single white crow will falsify it.

So, what has this to do with constructivism? According to Mahoney this type of epistemological approach is consistent with constructivism. A theory is often considered to be the best explanation because it has not been refuted, not because it is indubitable. He argues that ideas transmute over time, not necessarily toward a perfect end point but toward an ever-changing one. Goals are seen as personally and socially defined, hence as the needs of these domains change, so too do their goals. As shown, Mahoney's constructivism makes claims about personal meaning systems and collective meaning systems, so the goals mentioned above are those of individuals and science in general.

Like Neimeyer, the central focus of Mahoney's work is the treatment of psychological problems. As noted by Mahoney (1988b) constructivism takes a particular approach to the construal of such problems. A problem is often viewed as a coping mechanism as opposed to a malfunction. While the symptomatology may create difficulties for the individual, it is not therefore seen as inherently pathological. The approach is therefore an essentially positive one, in that the 'problem' is seen as a response to a challenging situation, a response which may have been the best (or only) option at a particular time. The context in which the problem arose is considered and included in the clinical picture. Problems are not analysed in isolation from other individual variables or environmental factors. The individual is understood as a whole, with many interwoven facets which are rooted in a unifying and form giving, deep underlying structure.

So problems which may appear quite superficial and isolated, may signify more profound and pervading disruption. Mahoney states:

This shift of focus is conceptualised as moving from the *problem level* (current episodes of dysfunction or distress) through the *pattern level* (recurrent regularities in problems) and finally to the *process level* (generative and ongoing anticipatory constructions that contribute to the perpetuation of the patterns (Mahoney, 1988b, p. 304).

One of the primary benefits of therapy which is directed at the 'process level', is that clients gain insight into some of the assumptions and constructs which filter their experiences and behaviours. And this creates a capacity for change which would be more limited under traditional problem-focused approaches. According to this method the problem is not ignored and nor is its significance underestimated. Rather, the mechanisms and patterns of operation which have allowed it to develop are analysed so that (if necessary) more fundamental change can be effected. It appears that the differentiation of Mahoney's three levels of intervention, is not clear cut. There would be much overlap and interconnectedness. What the explication provides is essentially a paradigm for guiding the understanding and treatment of psychological disorders.

Although there may be many similarities in symptomatology across individuals, people respond differently to them. And the response becomes part of the dilemma. What is particularly important for the constructivist is 'meaning'. One must ask the questions: what does this problem mean to this person? In what way is it connected with, or disconnected from, their construct system? And what underlying mental processes are supporting it? Obviously these questions are quite abstract and difficult to answer. They create challenges for both the therapist and the client. Mahoney uses a variety of therapies, including Gestalt and Humanist techniques to meet these challenges.

Mahoney is one of few constructivist theorists to discuss the role of emotion in psychological dysfunction. He notes that many analyses of mental disorder assume that such problems are essentially emotional. For example, emotions such as anger and depression are often viewed as central to psychopathology. The DSM-IV, for instance, lists several disorders which are characterised by low mood or excessive despondency. Mahoney states that intense emotions are sometimes described as having "...a disorganising influence on the individual" (Mahoney, 1988b). According to Mahoney the constructivist view of emotionality is quite different. Emotion, even when it is excessive is not construed as inherently disorganising and therefore as something which

must be eradicated. Rather it is seen as a potent and primal type of experience which yields a particular type of knowledge. What this means is that the experience of an emotion may yield insight into one's state of being which may not be available through any other encounter. It is therefore considered valuable in that it plays an important role in the regulation and organisation of experience. An uncomfortable emotion may in this sense be understood as a necessary phase or process which occurs when change and/or growth are taking place.

This view does not deny that often people are adversely affected by extended periods of feeling depressed or anxious. Such periods do not appear comfortable or productive. A constructivist however looks at emotion in a context not at emotion per se. Specifically its role is examined in relation to its place within the individual's other psychological systems. So the emotion itself is generally not the target of therapeutic intervention, but rather a person's total experience which is showing dysfunction in the form of intense emotion. In this sense excessive or disordered emotion may be seen not as the root or cause of the problem but as a symptom or component of it.

Like Neimeyer, Mahoney may be criticised on the grounds that his theory of knowledge is ultimately relativistic as he states that the world can only be known 'individually and imperfectly.' A major problem with this view is the inevitable relativity of all ideas. Mahoney argues that ideas change over time in response to personal and social need through a process of acceptance and refutation. However this ignores the possibility of objective verification which seems plausible according to Mahoney's views on ontology. If the existence of a real world is acknowledged then it is also necessary to acknowledge the influence of that world on the development of ideas. Mahoney argues that this can only be known imperfectly due to the complex processes of interpretation which necessarily affect the objects and phenomena under investigation. However this position is problematic in that there is therefore no common ground for scientific study. In many areas of science this relativist stance appears inappropriate. For instance, one can observe and report that water boils at 100 degrees Celsius without having to apply one's distinct mental processes. In this case such processes have no bearing on the description of the phenomenon in question. Like Neimeyer, Mahoney fails to acknowledge to a sufficient extent, the external constraints on the interpretation of events.

However, whereas Neimeyer's relativist position is primarily social, Mahoney's is individual-centred. For Mahoney, each individual has his or her own unique understanding of the world which is a function of a unique psychological make-up. In contrast to this position, Neimeyer stresses the commonalities between people, proposing that while there may be individual differences, there are more powerful socio-culturally defined similarities. According to Mahoney, each individual is the centre of his or her universe and hence each understanding of the universe is different. Neimeyer, on the other hand, argues that people subsume the views which are predominant in their society and that therefore their knowledge of the world will be a product of those views. The difficulties with these two approaches lie not in the ideas per se, but in the extent to which they taken. The account of constructivism which I will advocate will draw on both of these views. I will argue that both individual and social factors play an important role in the development of knowledge but also that the influence of these factors is mediated by the data and phenomena under investigation.

### *SOCIAL CONSTRUCTIONISM & SOCIAL CONSTRUCTIVISM*

There is an important distinction, requiring clarification, between constructivism and the related theoretical position of social constructionism. Social constructionists (and social constructivists), such as Gergen (1985) claim that knowledge is not objective and is therefore not an accurate representation of the objects and phenomena which it seeks to explain, but rather is relative to its socio-cultural context and is therefore inextricably tied to that context. In other words knowledge is an artefact of the social environment out of which it emerges. That environment consists of the language, beliefs and values of its inhabitants. Language plays a key role in social constructionism. Language is seen as the medium through which individuals ascribe meaning and glean understanding. It is the structure in which all ideas are embedded and it therefore delineates and constrains knowledge. Individuals use language, not only to communicate with one another, but also to subjectively interpret the world around them. Hence subjective interpretations within a social group are not viewed as radically different from one person to the next. Rather they are seen as similar due to their common linguistic origin.

This position can be traced to Vygotsky (1934) who asserted that mental activity arises largely out of what may be termed the 'privatisation' of social and interpersonal activity (Harre, 1989). Experiences are mediated by the concepts and conceptual structure of language. For instance, the referents of a language which are used for particular emotion states, shape the way in which emotions are experienced and interpreted. But well before Vygotsky, Vico noted the power of language and symbolism in human, and in particular, scientific understanding. Vico was especially interested in the *process* of knowledge development which he saw as being inextricably connected to the linguistic devices which it employed. Wittgenstein (1953) also wrote of the primacy of language in the acquisition of meaning and the development of knowledge. Language for Wittgenstein is the centre of human psychology, as linguistic practices are seen to determine the nature of thought and the nature of science.

Social constructionism may be viewed as one type of constructivism, one which emphasises the significance of language in human knowledge systems and one which relatedly adheres to the thesis of radical relativism. In contrast to the relativism seen in the ideas of Mahoney and Neimeyer, social constructionists argue that knowledge is entirely a product of socio-cultural factors. While Mahoney and Neimeyer both stress the primacy of such factors in human understanding, they both also acknowledge the existence and influence of the 'objects' of inquiry, which although can not be known directly, still play a part in the formulation of ideas.

Central to social constructionism is the view that knowledge is relative to cultures and their particular beliefs and values. It is essentially a social product. In this sense constructivism, and certainly the version of it which I utilise, must be distinguished from social constructionism. Constructivism places less importance on the social realm. Its epistemology places equal emphasis on both society and the external physical world. While language is viewed as an important mediator of the interpretation and explanation of phenomena, language in turn is viewed as mediated to some extent by the phenomena which it seeks to explain.

To illuminate this view one can turn to the analogous proposition in evolutionary theory known as 'structural coupling'. As described by Varela, Thompson and Rosch (1991)

this refers to the interaction and correlation between organism and environment. According to the traditional Darwinian view, organismic structure is seen to respond to, and adapt to, changes in the environment, in what is essentially a one-way relationship. In contrast, the thesis of structural coupling proposes that habitats and their inhabitants co-evolve in response to an elaborate reciprocal relationship, wherein each necessarily influences the other. Accordingly the social and physical worlds may be seen to interact, although in a rather different sort of way. The objects which comprise the external environment – which may be termed hard data – necessarily influence the way in which the data may be described and explained. And, in turn, the way that the data are described may affect the way that the data are perceived. So the description does not loop back onto, and therefore impact on the hard data themselves, but on the perception and interpretation of the data. This concept formed an important part of Piaget's philosophy; he often referred to the dynamic interplay between individual and environment.

## *SUMMARY*

This chapter has presented the ideas of a variety of constructivist theorists, chronologically, thereby explicating the concept of constructivism and showing its development over time. This began with a look at its general philosophical roots and ended with a detailed discussion of its manifestation in contemporary thought. Also explained was the important distinction between constructivism and its 'sister' theory social constructionism. The latter is more strongly relativistic, stressing in particular the role of language in human understanding.

Within this historical discussion can be seen the intersection of constructivism and psychology which will be drawn out in the remaining chapters. The following chapter draws on the material in this chapter to create a definition of constructivism and subsequently, a definition of mental disorder.

## CHAPTER 8

### A CONSTRUCTIVIST DEFINITION OF MENTAL DISORDER

This chapter offers an alternative approach to the understanding of mental disorder; an approach which has a number of advantages over the traditional bio-medical-oriented construal which has been shown to be problematic in a number of areas. In particular, the biomedical model is unable to explain or even acknowledge the significance of culture in the manifestation of psychopathology. Clearly mental disorders are strongly shaped by social forces, both in their respective manifestations and in their various interpretations, and more precisely, *classifications*, around the world. The DSM falls down at the point at which it seeks universal applicability. It acknowledges cultural variables yet in line with its underlying theoretical basis it asserts the ubiquity of its primary syndromes. Underlying this inconsistency is the DSM's definition of mental disorder which relies on the concept of dysfunction to delineate abnormality. In light of the relevant empirical literature this definition is arguably inadequate.

What is required is an alternative theoretical basis; one which allows for greater socio-cultural shaping of mental disorder, both at the levels of definition and classification. I will argue that constructivism provides an excellent theoretical foundation and framework for the development of an alternative and more compelling definition of mental disorder. Compelling, primarily in that it is more consistent with the empirical literature and hence that it provides a more accurate account of the relevant phenomena. These phenomena are the many and varied components and determinants of mental disorder, such as symptoms, biological correlates, diagnoses and social context. Through its characteristic multi-dimensionality, the application of constructivist ideas leads to a deeper and more complex understanding of mental disorder which can more readily incorporate its diversity world-wide. The bio-medical view relies too heavily on



the notion of intra-organismic dysfunction thereby understating the role of socio-cultural factors in psychopathology.

While constructivism has been frequently applied, in the field of psychology, to specialised areas such as psychotherapy and learning (e.g. Kelly, 1955; Prawat, 1992; respectively) it has not been applied to theoretical issues in clinical psychology. Hence it should be noted that some of the ideas that follow, are novel and should be viewed as experimental. In empirical psychology one tests novel hypotheses against observable data and often novel propositions are presented along with their empirical support. In contrast the evaluation of a purely theoretical work (while also related to empirical phenomena) is to a large extent, the discourse which follows the proposition. It is hoped that at the very least these ideas will contribute usefully to discussions of these issues. They are not intended as final answers to the numerous complex questions which have been raised. One of constructivism's defining features is its self-reflexive acknowledgement of the permutation of theories in accordance with the vicissitudes of the social milieu. Hence those who proffer constructivist theories must be aware of the fallibility of those theories.

Beginning this chapter is a detailed explication of the definition of constructivism which I will be employing, which draws on many of the ideas expressed in the previous chapter. Following this I present a constructivist definition of mental disorder, which I contrast with the traditional contemporary view.

### *A DEFINITION OF CONSTRUCTIVISM*

The previous chapter laid the foundation for a definition of constructivism by outlining the views of a number of key figures who have contributed to the delineation of the concept over the last two hundred years. The definition of constructivism which I utilise draws on these views. The key ingredient of constructivism is undoubtedly, and not surprisingly the notion of construction. Essentially this relates to the process of understanding and ascribing meaning. It is claimed that individuals actively construct their experience according to the various meanings and interpretations which they impose on the world and their connection with it. While the existence of a real world is acknowledged, what is seen as of primary importance are the numerous ways in which

this world can be interpreted and explained. The concept of construction describes the process by which these interpretations and explanations are created.

Another important aspect of constructivism – one which has not been emphasised by all of its advocates – is the view that the human mind is rational. It seeks order; it attempts to make sense of complex stimuli; it acquires understanding through reason. By reason, I mean thinking critically and systematically about ones beliefs, intentions and actions in order to optimise ones situation.<sup>1</sup> Without this ability our constructions would be useless as they would not enable effective living. Without reason these constructions would bear no relation to the external world. They would simply be misunderstandings which would result in horrors such as stepping into the path of an oncoming vehicle and eating the berries of a Belladonna plant. While constructions will differ from one person to another there is a significant amount of overlap due to the constancy of the external environment and the similar application of reason. Reason, perhaps, is a common language; one which places vital constraints on constructions and affords people the ability to interpret complex arrays of stimuli, in ways which lead to effective negotiation of the environment. Kant was a notable purveyor of this aspect of constructivism and more recently Mahoney has reiterated it.

Combining these two components of constructivism - ‘construction’ and ‘reason’ - one gets at the essence of the concept; that human beings use their rational minds to understand, and ascribe meaning to, the world. This process, of understanding, and deciding what things ‘mean,’ involves selection and interpretation. It is not possible for individuals to attend at all times to all stimuli that present themselves to all the senses. What are considered to be important stimuli, are given more attention. So, constructivism also involves ‘selection,’ wherein people actively seek out, or ignore particular data. Due to physiological and psychological limits, capacities and abilities are finite, and hence there is a need to manage mental and physical resources in ways that maximise their utility. In this sense individuals’ experiences of the world may differ according to their psychophysiology, their knowledge, and their goals. This point was highlighted by Vaihinger, who claimed that the psyche, in interpreting, actively

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<sup>1</sup> Hooker (1994) provides an excellent definition of reason. He states: “Reason is that capacity in virtue of which, within our finite resources, we transcend our imperfections. Reason is a capacity, operating at

imposes itself on stimuli, thereby altering them according to its own requirements. Dewey described this with the term 'transformation', meaning that the process of gaining understanding and acquiring knowledge involves a transformation of data according to and depending on the selective attention of the knower.

Similarly Piaget posited the notion of 'assimilation', referring to the way in which experiential data are incorporated into existing cognitive structures. He also proposed the term 'accommodation' referring to the structural change in the individual which occurs in response to exposure to novel stimuli. This is another important element of constructivism; one which Soldz (1988) referred to in his summary of the essential features of constructivist theories. Construction refers not only to the transformation of incoming data, but also to changes at a personal level. As information is integrated into cognitive systems, changes take place within the system, especially in the case of the interpretation of novel stimuli. There is a complex interaction between organism and environment wherein the environment stimulates change in the organism and the change in the organism in turn influences the interpretation and assimilation of environmental variables.

This interaction between the organism and its environment highlights the significance of 'context' in the understanding of behaviour.<sup>2</sup> Kelly, in particular, noted that human beings interact meaningfully with their environments and that therefore human behaviour must be viewed and explained within the context that it occurs. Pepper's (1942) concept of contextualism aptly captures this idea. As explained in the previous chapter, this concept is one of Pepper's four alternative world views. Contextualism refers to the proposition that understanding and explanation are rooted in a complex array of inextricably connected events. He uses the notion of horizontal cosmology to describe the idea that truth will not be found by peeling away layers and getting to the

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both individual and collective levels, to replace ignorance with information, reactivity with systematic judgement, prejudice and partiality with critical appraisal, and so forth" (Hooker, 1994, p. 223).

<sup>2</sup> While I use the terms 'context' and 'environment' here, interchangeably, there is a subtle difference which requires acknowledgement. In my view, 'context' is a broader concept which *encompasses* 'environment,' in other words the environment of an object or phenomenon is one aspect of the context of that object or phenomenon.

bottom of things, but rather by looking at the totality, the whole, and the relationships between the parts which comprise the whole.<sup>3</sup>

A vital aspect of the context of human existence is the social dimension which forms an important part of constructivism. Vico emphasised the significance of social variables, in particular, symbolism and language, in the formation of knowledge. And more recently Neimeyer (1993), in his exposition of constructivism stressed the prominence of social forces in the development and crystallisation of belief systems. While he acknowledges the role of the individual in ascribing meaning to phenomena, he notes also that meaning is dependent on the beliefs and values of groups, or cultures. He states that human knowledge is '(inter)personal', suggesting that constructions are shaped to some extent by societal factors. While some constructivists centre meaning firmly in the individual, the definition of constructivism used herein takes the approach of Vico and Neimeyer and realises the profound influence of the social dimension in human existence. Held (1995) concludes after careful observation, "...that constructivism as it has been conceptualised recently does not preclude a social component" (p. 310). This appears to be the case, but its emphasis varies greatly from one author to another.

The interaction between socio-cultural variables and data interpretation is of fundamental importance to constructivism. But unlike social constructivism it does not preclude the existence and influence of a real external world. Linguistic referents are not entirely dependent on culture, but are rather significantly shaped by the objects and phenomena which they seek to delineate. In this sense, constructivism is only anti-realist insofar as it denies that the external world can be known perfectly and directly.<sup>4</sup> It does not deny the existence of the external world. This is the ontological position which I will be adopting. It is not one taken by all constructivists, and it is certainly not the view of most social constructionists. But it is the position which Mahoney sees as characteristic of constructivism.

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<sup>3</sup> This view is similar to the thesis of 'holism' which claims that the whole is more than the sum of the parts, and hence to gain an understanding of the whole, it is necessary to look at the properties of the whole rather than the properties of the individual parts which comprise it. This can be contrasted with reductionism.

<sup>4</sup> There are of course different types of realism, however I use the term here as it is most commonly used, to denote the view that physical objects exist in the world irrespective of whether or not they are perceived.

Another important feature of constructivism is the role of the individual. Unlike social constructionism which sees all meaning and understanding as being rooted in social networks, constructivism claims that there is some degree of uniqueness (Viney, 1992). In other words, constructivists argue that there are individual differences in meaning. People perceive, interpret and explain the world from their own unique vantage point which is a combination of their genetic inheritance and their particular set of life experiences. Although individuals are greatly influenced by their socio-cultural environments, it is argued that they also evoke their own private conceptions in the process of negotiating the world.

Lastly, constructivism sees knowledge not as a static body, but rather as an ever changing, and ideally, ever improving entity. Whether or not, this knowledge is 'objective' and 'true' is not important. What matters is its utility; its applicability to a particular time and place. Vaihinger saw the utility of ideas as being central to the process of their construction and to their continuation. So, a belief may rest on false premises yet still serve a worthwhile purpose. What is most important, according to this epistemology is the extent to which an idea can contribute to an individual's survival and to the survival of society as a whole. Generally, there should be a fit between what one believes to be the case and what is the case. The greater the correlation, the greater ones chances of surviving in a complex environment. But sometimes alternative beliefs and understandings may lead to the same outcome. For instance whether or not one believes in an afterlife makes no difference to the fact that we will all physically die. Vaihinger might argue that religious belief of some sort is useful whether or not it is the 'truth.' The point I want to emphasise here is simply that knowledge changes; what is considered to be scientific fact today may not be centuries, or even just decades, from now.

To summarise then, constructivism sees knowledge as grounded in both a real external world and within individuals (and their socio-cultural context); although the former is seldom available directly. Human beings use their rational abilities and their linguistic devices to make sense of the world and in doing so actively *construct* their experiences and explanations. This construction is strongly, although not entirely, mediated by social context; there are individual differences and hence there may be some

uniqueness of meaning. The value of knowledge is not measured against a yardstick of objective truth, but rather against a yardstick of utility. Ideas should be useful; they should enhance survival; they should enable efficacious living.<sup>5</sup> Hence as human goals change, the knowledge base changes. This is not to say though that knowledge, and say, science, does not map the world to an accurate degree; it may. But science is progressive; theories change in response to fresh data and fresh ideas. Constructivism acknowledges this permutation and sees value and utility in the process rather than aspiring to an ideal end point. This process serves humankind and hence knowledge must be seen as, to some extent, a product of humanity.

## *CONSTRUCTIVISM AND CROSS-CULTURAL PSYCHOLOGY*

In Part Two I provided an overview of the cross-cultural literature as it pertains to the definition and classification of mental disorder. I discussed the history of cross-cultural understanding in the West, generally, and in psychology, thereby describing the climate in which contemporary ideas have developed. Clearly, in the past, ethnocentric attitudes have influenced science and perhaps especially the social sciences, however there is now a greater tolerance and understanding of cross-cultural differences. But arguably, this tolerance and understanding has not permeated the traditional Western approach to the definition and classification of mental disorder which still asserts the universality of its primary syndromes.

Cross-cultural studies of these syndromes suggest that there are substantial differences in their manifestations across cultures. The two disorders which I looked at in detail, namely schizophrenia and depression, show significant differences across ethnic groups. This calls into question the underlying bio-medical conception of mental disorder which underpins the traditional approach. An alternative conception is required, which can acknowledge the important influence of socio-cultural factors and can hence explain these differences. The central weakness of the bio-medical view is the inability to incorporate variables such as context and meaning in the experience and manifestation of mental disorder. As with many aspects of human existence, the

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<sup>5</sup> This position is consistent with 'pragmatism,' a term used by James and Dewey, among others, to refer to the view that knowledge is the body of ideas that have proved useful (A dictionary of philosophy).

phenomena of mental disorder influence, and are influenced by, both the socio-cultural context in which they occur and the individual response, which consists in part of the process of ascribing meaning.

According to a constructivist approach, this process is fundamental to the understanding of mental disorder. Seen as central, is the way that individuals interpret experience as this, in turn, influences the experience and the disorder. Whereas the traditional bio-medical view sees a mental disorder as a dysfunction within the individual, a constructivist view sees it as a complex process involving a diversity of interacting factors, with intra-organismic dysfunction as just one of these factors. If there is dysfunction, what is important is the way that it interacts with individual and socio-cultural variables. The following example illustrates this interaction.

### *An example*

Harrington (1993) describes the unusual sexual practices of the Sambia, a people who live in a remote rain forest in New Guinea. Central to these rather unique practices is the belief that boys must ingest semen in order to become masculine. Between the ages of about seven and ten years, boys are forcibly introduced to the practice of fellatio by older males in their community. And for the next ten to fifteen years the boys engage in homosexual activities; firstly prior to adolescence as fellator and then as fellatee. During the first few years of marriage most men are bisexual, but when they become fathers they typically become strictly heterosexual. According to Sambia tradition this early compulsory introduction to homosexual oral sex enables the development of strength and virility, and a smooth transition from boyhood to manhood.

As noted by Herdt (1981) Sambia men do not appear to be adversely, or otherwise, affected by their adolescent homosexuality later in life. Most become exclusively heterosexual following marriage and fatherhood. What is most interesting is the link between these sexual practices and the Sambia beliefs about male development. It is thought that if boys do not ingest semen they will not reach their full physical potential. This belief is a vital part of the ritualised homosexuality, encouraging boys to see the experiences as beneficial. In Western societies sexual practices of this sort are prohibited, for many reasons, but primarily because they have detrimental effects on

children. In the West it is considered morally reprehensible to subjugate children in this manner. What is considered beneficial in one culture is considered detrimental in another. It is likely that because of the beliefs which surround homosexual practices in Sambia there are no ill effects. Boys believe that it is normal and necessary and therefore even if they find the acts unpleasant they may gladly endure them if they believe that such activities guarantee their normal development.

This snippet of Sambian life illustrates the intersection between constructivism and cross-cultural psychology. What is important here is meaning. Fellatio in Sambia has special significance; it is part of complex, ritualised social behaviour. As Harrington points out a psychoanalyst may ascribe much importance to a fifteen year history of homosexual fellatio which began with the boy's father introducing him to a male friend or relative. Undoubtedly many personal difficulties may be linked to what could easily be termed 'abuse'. But such a label would be misplaced if within that boy's culture such behaviour was considered 'normal'. The context of life events and the way that events are experienced are inextricably connected to the events themselves. It is not the sexual act itself which has significance here, but the socio-cultural beliefs and practices in which it is embedded. With regard to sexuality, concepts of normality and abnormality must be applied with respect to socio-cultural context.

Similarly psychopathology occurs in a context. Behaviour is mediated by beliefs and values which are always culture centred. And likewise the breakdown of behaviour has similar constraints. These constraints work in two ways. Firstly, behaviour is influenced by implicit rules governing that which is considered normal. In other words even when people are mentally unwell they will still attempt to conform to the expectations of those around them. And secondly, behaviour is influenced by folk conceptions and folk categories of mental disorder. In other words people who are mentally ill will be affected by their own ideas of mental illness and by what they believe is typical of people who are 'mad' or who have 'lost their minds'. Of course there is more to mental disorder than disordered behaviour. Also important are individuals' subjective experiences of their conditions which are an important dimension of psychopathology. Subjective experience, also, is powerfully influenced by social factors. The words



which are used to interpret the experience of emotion, shape the way that emotion is experienced.<sup>6</sup>

The social context and social mediation of mental disorder have been demonstrated in previous chapters and accordingly the traditional biomedical approach has been criticised. As an alternative to this approach constructivism provides a conceptual foundation which is arguably advantageous because it can more readily account for socio-cultural diversity, and more generally, because it has greater explanatory coherence. The following section outlines a definition of mental disorder built on this constructivist foundation.

### *A CONSTRUCTIVIST DEFINITION OF MENTAL DISORDER*

As shown in chapter one, there are a number of problems with contemporary definitions of mental disorder. And moreover as shown in part two, both the definition provided in the DSM-IV and Wakefield's definition are too rigid in their approach, asserting an homogeneity of mental disorder which is not consistent with the literature on the nature of various disorders. For example both definitions claim that mental disorder must involve dysfunction yet historical analysis reveals that there have been disorders in the past which were entirely social in nature. Moreover, as powerfully argued by Lilienfeld and Marino, dysfunction suggests a 'natural' element to disorder which may not always be present. While both definitions acknowledge the important role of social variables in psychopathology these variables are implicitly downplayed by the need for them to be always and necessarily tied to the notion of dysfunction. According to the DSM-IV, dysfunction may be behavioural, psychological or biological, but common to all these manifestations is the idea that something is going wrong within the organism. In this sense the concept of dysfunction embodies the biomedical understanding of mental disorder which sees various disorders as distinct disease entities (Thakker & Ward, in press).

Wakefield is more explicit in his analysis of dysfunction, tying it firmly to evolution and its manifestation as adaptive function. Apart from the problems with this analysis which were discussed earlier, like the DSM definition, Wakefield's approach mistakenly

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<sup>6</sup> This point was discussed in detail in chapter 5.

asserts that functional breakdown of one sort or another underlies all disorders. Like medical conditions, psychopathologies are seen as discrete disease entities. However, arguably, due to their strong social component this definition places undue emphasis on internal processes to the exclusion of socio-cultural influences. The two aspects of his definition, represented by the concepts of 'harm' and 'dysfunction' are both necessary and sufficient for mental disorder. The central problem here lies not with these aspects of disorder per se, but with the rigidity with which they are explicated. Accordingly, I will argue that a definition of mental disorder based on constructivist principles provides a more legitimate account of the concept; legitimate in the sense that it is consistent with the current views and theories on psychopathology in the empirical literature. And more specifically, it is able to acknowledge and embody the diverse manifestation of psychopathologies across cultures.

### *A constructivist definition*

In earlier chapters I have argued that mental disorder is influenced powerfully by social variables. Entirely bio-medical and naturalistic explanations are unable to incorporate human diversity and impose too restrictive an approach on the understanding of psychopathology across cultures. A definition of mental disorder should acknowledge the tremendous variation across peoples and admit also that little is known, at this time, of the psychophysiological mechanisms which underlie most disorders. Though this is not to say that such correlates or perhaps origins are not to be found - they may be. I will propose, like Wakefield, that a definition of mental disorder should consist of both social and biological components, however I will also include an active self which interacts with these variables.

It is the 'self' that is central to a constructivist analysis of mental disorder because it is here that construction takes place. In the words of Piaget, people assimilate and accommodate; they use language to interpret and to evoke meaning and in doing so they construct their realities. In this way individuals place their own unique stamp on their shared biological and social worlds. So to some extent every incidence of a mental disorder is unique, because the process by which it comes about has individual input. And of course mental disorder is primarily something that happens to people, in the

form of subjective experience. This experience, while constrained by social and biological forces is not entirely dependent on them. These forces are moulded according to the details of life events and personal interpretation which are always unique. This means that two people in the same socio-cultural environment may experience a similar symptom array rather differently.

So firstly, a mental disorder is something that happens to or occurs within a person. This may seem trite, but it nonetheless requires affirmation. In the definition which I espouse, I refer to all factors relating to the personal aspect of disorder as the 'self'. This includes the experience of psychopathology, the meaning which one ascribes to this experience, and personal/historical factors such as personality, life experiences, and goals. Essentially the 'self' may be seen as the centre of personhood - as all those aspects of an individual's existence which are unique to him or her. According to a constructivist perspective this unique 'self' would invariably influence the manifestation of psychopathology because even if there are significant physiological and socio-cultural components to mental disorder these components must connect within the individual. And due to the active, dynamic nature of the 'self' within the individual, there is imposed on the manifestation of disorder, a unique experience and idiosyncratic interpretation of phenomena.

As well as the personal dimension, my constructivist definition of mental disorder has three other components: biological, psychological and socio-cultural. The biological component consists of physiological dysfunction - that is, the breakdown or disruption of physical processes - and more distal biological correlates such as genetic predisposition. While the term 'biological' may seem vague, it has been chosen not for its precision but for its breadth. It must include natural history, natural (or physical) environment and physiological factors all of which impact on mental disorder. Like other animals, *Homo sapiens* are a product of a complex evolutionary past which continues to exert a powerful influence on our behaviour. While at times I emphasise the role of social factors in psychopathology I do not want to imply that biological variables are unimportant. My main criticism of theories in this area which refer to biology, is that they often fail to acknowledge the equally important role of society and culture in their explanations.

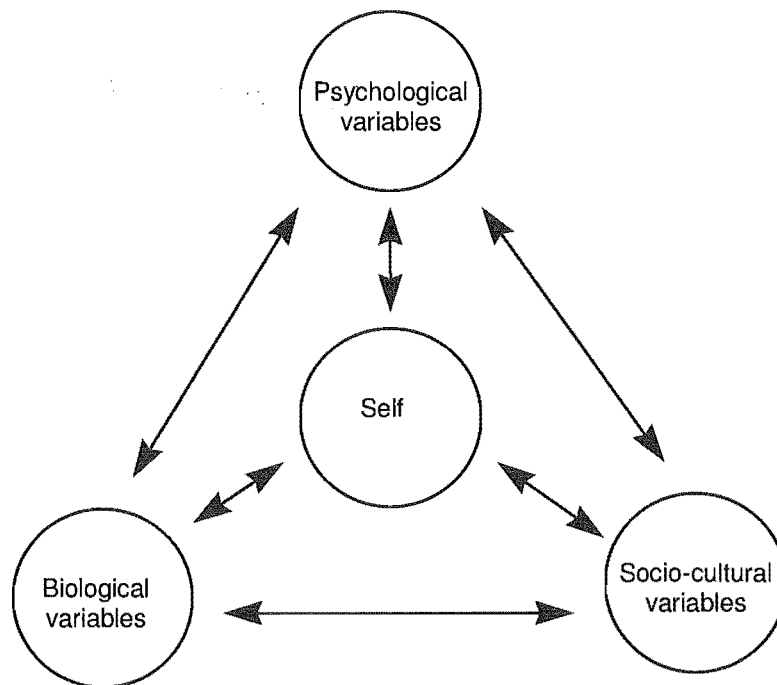
Psychological variables are mental mechanisms and mental processes such as attention, face recognition, information processing and memory. These mechanisms and processes are of course central to mental disorder as the term itself denotes the disruption of psychological functioning. Different syndromes are characterised by different types of psychological disorder. For instance, dementia involves global cognitive impairment, in particular the breakdown of memory systems, while depression is indicated by disordered emotion. It is important to note that most mental disorders are at this time distinguished by psychological variables, rather than biological or socio-cultural factors. Symptom lists typically refer to 'abnormalities' in psychological functioning, such as low mood, delusions and obsessive thinking.

Socio-cultural variables make up the third and last component of my definition of mental disorder. This refers to the social context of disorder which includes the language, beliefs, values and customs of a society. A mental disorder typically involves a violation of social value; that is a person will behave in a socially unacceptable manner or in a manner that is beyond the understanding of other people. And moreover the disordered individual will be influenced by his or her socio-cultural environment even in their disordered state. It is important to note that even in a state of psychological distress or disability a person will still speak their own language, wear a particular type of dress and obey some social norms. I want to argue that even in cases where people depart from these traditions they may still be affected by them.

So the social aspect of mental disorder can be seen at two levels: The level of manifestation in the individual and the level of explanation. The former refers to what happens to the person and the latter refers to how we interpret what happens to the person. It is important when discussing the nature of mental disorder to distinguish between these levels and acknowledge that the explanation of mental disorder is not the disorder itself. As explained above, socio-cultural variables are evident at both levels. They are part of the presentation of disorder and they influence how the disorder is understood. The constructivist definition which I am proposing refers to both of these levels of socio-cultural influence.

The four aspects which I have presented are seen as interacting in the manifestation of psychopathology. While the 'self' must be seen as central, insofar as it is the point at

which the other variables intersect, the other three components - biological, psychological and socio-cultural - are seen as equally important. Together these components form a dynamic system wherein each aspect influences, and is influenced by, all of the others. This system is depicted in figure 3. Illustrated here is a complex system of interacting variables with the self placed in the middle surrounded by the three other dimensions. The self may be seen as the central processor through which the various aspects of psychopathology interact. However, as indicated by the external arrows, there are also direct interactions between the other aspects. So, for instance, biological factors are seen to directly influence psychological factors. It is not necessary therefore for all interactions to occur via the 'self.' Using the above example, it may be the case that in a particular disorder, neurochemical changes lead directly to changes in psychological functioning.



*Figure 3.* Diagram of a constructivist model of mental disorder

Importantly though, what is central to this constructivist understanding of mental disorder is the notion of a complex system with the 'self' at the centre; a system within which each of the components affects each of the others. According to this view a mental disorder is a systemic breakdown involving the disruption of one or more aspects or levels of functioning which in turn impinges on the system as a whole.

However, significantly, different disorders may be more powerfully influenced by different parts of the system. For instance dementia clearly has a strong biological component. Evidence from autopsies of those suffering from Alzheimer's disease - which is a leading cause of dementia in the elderly - reveals significant neuronal loss in the cerebral cortex (Kowall & Beal, 1988). Other causes of dementia include Creutzfeld-Jacob disease - a rare viral disease - and meningitis - a (usually) bacterial infection of the membranes surrounding the brain. Dementia, then, typically has a distinct physiological component which causes or contributes powerfully to its manifestation. Hence, while according to the definition of mental disorder which I have proposed, there are important interactions between the physiological and other aspects of the system, an understanding of this condition may centre around the biological etiological factors.

In contrast anorexia nervosa which has been described, by some researchers, as a Western 'culture-bound syndrome' (e.g. Banks, 1992; Simons & Hughes, 1985; Kaplin, Sadock & Grebb, 1994), may be a more socio-culturally embedded mental disorder, revolving around the Western idealisation of female slimness. What I have attempted to illustrate here is that mental disorders are a heterogeneous class of phenomena, and hence there is a need for a definition which can allow for different etiologies and varying emphases on the diverse aspects of their manifestations. Accordingly, this construal of mental disorder proposes that there are a number of important variables which are involved, but that different disorders may differ with respect to the extent to which the various aspects are implicated.

In summary then, a mental disorder is conceptualised herein as a systemic failure or disruption, wherein the system consists of four primary dimensions - psychological, socio-cultural and biological and the 'self,' all of which interact with one another. The self though, is seen as central as it is through the 'self' that the other dimensions come together. The 'self' is the point of experience and the point of manifestation. It may be seen perhaps as an emergent property of the other variables. Yet it is not therefore passive but rather an active point of awareness which is continually seeking to interpret and understand. The 'self' can also be understood as consisting of the other components to the extent that it relies on them for its existence. For example, self-awareness often utilises an internal dialogue which relies on the use of language. And

obviously in order to carry out an internal dialogue one must make use of psychological mechanisms and more fundamentally, the brain. The self, then should not be viewed as separate from the other components of the system but as dependent on them.

One might ask in what way this definition as depicted in figure 2. represents a constructivist philosophy. Firstly it acknowledges both natural and social elements, as constructivism assumes the existence of a real external world as well as an individually and socially constructed one. Secondly, and most importantly, the unique 'self' is seen as central to the manifestation of disorder. And the 'self' is submerged in psychology, biology and culture depicting the notion of a complex symbiotic relationship. While the 'self' is surrounded by these variables, it is assumed that it realises them uniquely. What is referred to here is the idea that while there will be considerable similarity across human beings in the nature of their biological structures, there may also be differences due to the complex interactions between the various aspects of the system. And likewise for psychological mechanisms and socio-cultural factors. Inevitably the idiosyncrasies of the 'self' affect all other aspects of the system.

This holistic approach is an important aspect of constructivism. A complete understanding is dependant not on an investigation of isolated elements but on an investigation of the connections and interactions between different aspects of the system. To explain a mental disorder one must attend to all of these variables. Particularly important according to a constructivist philosophy is the context of phenomena. According to the definition which I have proposed, the socio-cultural context is an integral aspect of mental disorder. Language, beliefs and values all impact on the experience and interpretation of psychopathology. For example, as discussed in earlier chapters, the somatic experience of depression among some Asian groups has been linked to language - in particular, the sort of words which are used to describe negative feelings - and to the social devaluing of the outward expression of emotion. These sorts of interactions raise a number of important questions, such as: How does language influence the experience of psychopathology - for example, do words like happy and sad mediate the experience of positive and negative emotions? And how do behavioural norms impact on 'abnormal' behaviour - for instance, are there still limits to what a person will or will not do?

Questions such as these would lead to a deeper understanding of the processes underlying psychopathology and of the dimensions of the process which are especially important in particular disorders. For example if schizophrenia appears to depend to some extent on various social variables, such as say, familial interpersonal relationships, then these variables should be investigated. Questions which could be explored might include: “What aspects of familial relationships are most pertinent to the onset and course of schizophrenia?” And, “What is therefore the best treatment approach? As explained in the chapter on schizophrenia one variable that has been implicated in the course of schizophrenia is expressed emotion. It is important to acknowledge that even though drug treatments are effective in controlling some of the symptoms of schizophrenia, there are important consequences in ignoring the social context of the disorder. If certain types of familial functioning contribute to the onset and course of schizophrenia then these factors must be addressed by treatment regimes. And similarly researchers must look at all the variables which are purported to influence the manifestation of schizophrenia so that treatment is optimised and health maintained over time.

According to a holistic perspective what is especially interesting is the way that one type of variable interacts with another in the manifestation of mental disorder. For example there is an important relationship between the ‘self’ and socio-cultural factors. As discussed in Part II, whereas in the West the notion of ‘self’ has strongly individualistic connotations, in many Eastern communities it is seen as having a familial or communal component. This difference in the understanding of the ‘self’ has implications for the way that mental illness is experienced and expressed. For example a communal conception of the ‘self’ may allow a diffusion of responsibility for illness which may lighten the emotional burden for the patient and encourage the acceptance of support. Connections between socio-cultural variables and physiological variables are also important. Many medical conditions, such as heart disease and stomach ulcers are now believed to be influenced by psychological variables, and there is generally a growing acceptance of the interaction between these levels of phenomena. In mental disorder too, it is likely that such interaction plays a major role.

Also central to a constructivist view is the possibility of alternative explanations; specifically the idea that different types of phenomena may require different types of



explanation. While all disorders involve a dysfunction with systemic consequences, different types of disorder may require varying emphases on different components of the system. For example, psychotic disorder due to a general medical condition clearly has a significant biological dimension, whereas dependant personality may be more socio-culturally based. Important here is the flexibility of the definition which acknowledges the tremendous diversity of psychopathology. This approach may be contrasted with the bio-medical view which sees all disorders as consisting of identical fundamental elements. While the definition which I have proposed also suggests that a number of elements are present across disorders, it also allows for the possibility that primary failure may be centred in different elements.

This point illustrates one of the primary advantages of my proposed model of mental disorder - that research may be more carefully tailored to the dictates of prevailing theory and that the theory itself is made explicit. This means that if a disorder is theorised to have, say, a strong social component then research should be aimed at establishing the social aspect of its origin and maintenance, rather than exclusively pursuing biologically oriented explanation. Such pursuance may detract from social need and draw funds away from areas where answers may be more forthcoming - according to prevailing theory. By seeing mental disorders as differently composed of various constituents rather than as a homogenous group there is greater scope for understanding. This approach demands an analysis of theory and its application to practical science, because the way that a disorder is studied must be consistent with its theoretical representation. And this is exactly as Hempel would have it.<sup>7</sup>

### *Contemporary views consistent with a constructivist definition*

The model which I have proposed is consistent with Littlewood's (1990) approach to the understanding of mental disorder. He suggests that explanations of mental disorder lie along a spectrum, as depicted in figure 3.

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<sup>7</sup> As discussed in chapter 2, many psychologists and psychiatrists have aspired to the incorporation of an Hempelian explication of theoretical issues in the contemporary understanding of psychopathology.

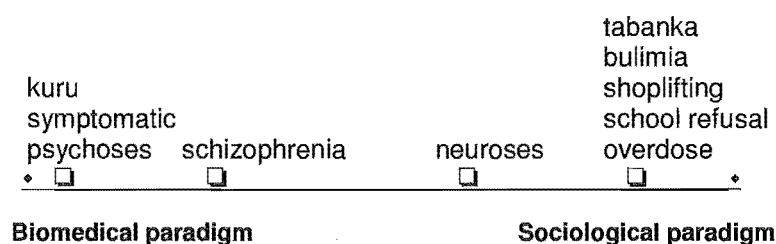


Figure 3. The explanation for patterns of symptoms can be taken as lying along a spectrum.<sup>8</sup>

Relatedly he states:

“Conclusions of widespread generality are inappropriate in psychiatry where ‘psychopathology’ includes patterns closely constrained by a discrete biological process as well as illnesses that can only be understood by paying close attention to individual personality, life experiences, and the symbolic meaning of the symptoms and the social response” (p. 318).

Littlewood recognises the heterogeneity of psychopathology and suggests that different types of explanation may be better suited to different sorts of disorder. As depicted in figure 2, kuru and schizophrenia may be most appropriately explained by a biomedical paradigm, and tabanka and bulimia by a sociological one. Similarly, my constructivist model of mental disorder incorporates both of these paradigms, and in doing so acknowledges the various influences on psychopathology and the corresponding importance of allowing for different types of explanation.

However with regard to the aforementioned distinction between the instantiation of disorder and the interpretation of that instantiation Littlewood is referring only to the latter. In other words he is not saying what a disorder is but rather what sort of explanations the various disorders require. Although the types of explanation should relate to the phenomena being explained. One can perhaps assume then that Littlewood sees mental disorder as consisting of both biological and sociological components.

Also consistent with a constructivist approach to the understanding of mental disorder, is the analysis of Lilienfeld and Marino (1995) who argue that it is best understood as a ‘Roschian concept’ which is characterised by unclear boundaries. They suggest that

<sup>8</sup> This diagram is an exact copy (including the title) of the one found in Littlewood (1990).

mental disorder may not have any “clear-cut natural counterpart.” They write: “Roschian concepts are organised around an ideal mental prototype that contains all the features constituting the category. Consequently, such concepts consist of both clear-cut (i.e., prototypical) and marginal examples” (p. 417). With regard to the controversy surrounding the question of whether conditions such as sadistic personality disorder and pre-menstrual phase dysphoric disorder are actually mental disorders, Lilienfeld and Marino propose that these disorders lie on the fuzzy boundary between disorder and nondisorder. This proposition rests on the argument that while concepts of disorder may be shaped by natural entities, they are not entirely dependent on them. They are highly critical of Wakefield’s presentation of an entirely scientific analysis of dysfunction, because it assumes that mental disorders map directly onto entities in the physical world.

To illustrate their point, Lilienfeld and Marino note, referencing Gorenstein (1992), that the concept of *drug* is similarly imprecise. The issue of whether substances such as caffeine and nicotine should be labelled as drugs, cannot be resolved with scientific criteria. However this fact does not undermine the reality of their physiological effects and nor does it imply that pharmacologists study fictional entities. Analogously, the symptom patterns which are labelled as schizophrenia, depression and panic disorder should properly be seen as objects of scientific enquiry, however the decision concerning whether they constitute disorders is a matter open to social discourse. Note that there is no attempt here to deny the very real manifestation of psychopathology. Rather, Lilienfeld and Marino want to emphasise the social embeddedness of the conceptual system which demarcates disorder from nondisorder and one disorder from another. Similarly, Klerman (1988) states that social constructs such as mental illness “...are not myths, or false, or arbitrary, but rather they embody shared consensus, social conventions. They are not facts given in nature, but ideas developed by social groups and legitimised by consensual validation...” (p. 74).

Discussing particular disorders, Lilienfeld and Marino propose, citing Meehl (1977, 1986), that most mental disorders display the properties of ‘open’ concepts, in that they are characterised by unclear boundaries, a lack of definitive indicators, and an unidentified inner nature. However they go on to say that this need not necessarily be the case. As noted by Meehl (1986) open concepts may later become closed if their

inner nature is revealed.<sup>9</sup> What this means is that as more is learnt about the object or phenomenon, to which a particular concept applies, the concept itself will become more sharply defined. In this case the inner nature would be the etiology and pathology of a disorder. To illustrate this point Lilienfeld and Marino give an example of general paresis which was, in their view, an open concept prior to the identification of the spirochete which causes syphilis. So, while little is known about a specific mental disorder, the concept which demarcates it may have unclear boundaries and be best characterised as open, but it will become more sharply demarcated with the acquisition of new information regarding its etiology and its physiological and psychological manifestation. But the metaconcept of disorder, according to Lilienfeld and Marino, will always be an open concept as the boundary between normal and abnormal is seen as inevitably vague. This is because there is no line delimiting normal psychological function and normal behaviour. Such discrimination is dependant not only on natural entities, but also on social value which responds to the vicissitudes of human endeavour and human need.

Also consistent with my definition and model of mental disorder is what Stein (1991) refers to as a 'position of synthesis' with regard to positivist and hermeneutic philosophies (which were introduced in chapter 2). As outlined earlier, the positivist view is, within psychiatry, the bio-medical tradition which characterises mental disorder as dysfunction. In contrast the hermeneutic perspective sees mental disorder as a socially determined category. Arguing for an understanding of mental disorder which combines these two philosophical positions, Stein proposes that while it may be possible to conduct scientific inquiry into the underlying mechanisms and processes of some conditions, it is necessary to acknowledge the role of socio-historical factors in contemporary conceptions of disorder. He writes: "Concepts of what constitutes mental disease, while theory-laden and value-laden, are nevertheless open to scientific improvement" (p. 409).

As Stein notes, although professionals are constantly revising their views on what constitutes a mental disorder, such revision is not arbitrary, but is rather based on a combination of scientific and social considerations. For example, as psychiatrists

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<sup>9</sup> A 'closed' concept is characterised by an explicit set of defining features, clearly demarcated boundaries and a thoroughly understood inner nature.

discovered the neurobiological underpinnings of Alzheimer's disorder they began to see senility as a disease rather than as a natural result of ageing. And as researchers realised that homosexuality is not linked with depression or personality disorder, there was a greater willingness to accept homosexuality as 'normal'. This ongoing process of revision and reclassification reflects the connection between social and scientific realms and emphasises the need for the representation of both explanatory paradigms in the understanding of mental disorder.

As evidenced in the ideas of Stein and the other authors referred to above, a constructivist approach to the understanding of mental disorder is not incompatible with all contemporary thinking. Rather it brings together the views of a growing number of theorists who see the need for a reformulation of traditional conceptions. Constructivism provides an underlying theory and framework for this reformulation which can account for the complexity and diversity of mental disorder and which can hence facilitate the development of a more accurate definition.

## SUMMARY

In this chapter I presented a constructivist definition of mental disorder after first briefly restating the shortfalls of the contemporary alternative. Central to this definition, and contrasting sharply with the bio-medical view is the idea that mental disorders are not necessarily characterised by intra-organismic dysfunction. While such dysfunction may play a role in some mental disorders I argue that it is not an essential factor. The constructivist definition which I presented centres on the 'self', which due to its inherent uniqueness, makes every experience and manifestation of mental disorder different to some extent. Interacting with this are biological factors, psychological factors and socio-cultural factors, suggesting that different disorders may be variously influenced by these variables. Central to this approach is the flexibility of the definition which acknowledges the diversity of mental disorder and hence proposes that one rigid definition can not account for all types of psychopathology. Also important is the idea that there is a complex web of interacting variables all of which together co-constitute mental disorder.

Concluding this chapter I discussed some contemporary perspectives which are consistent with a constructivist account. The following chapter explores the implications of this definition of mental disorder for classification, diagnosis and treatment. As will be seen, the definition that one utilises has important and wide ranging implications for many areas of clinical psychology.

## *CHAPTER 9*

### *IMPLICATIONS OF A CONSTRUCTIVIST DEFINITION FOR CLASSIFICATION, DIAGNOSIS AND TREATMENT*

This chapter looks at the implications of a constructivist understanding of mental disorder for three important areas of clinical psychology: namely, classification, diagnosis and treatment. For each of these areas I propose some means of integrating this understanding into current clinical procedures. The primary implication is the need to address contextual factors such as individual and cultural variables, which may be downplayed or overlooked by traditional approaches. The first section looks at how these factors may be addressed through the implementation of a dimensional classification system and some examples of such systems are outlined. The second section looks at incorporating context in diagnosis through the use of a context-sensitive nosology and a culture-sensitive assessment procedure. And the last section discusses briefly some implications for treatment.

#### *CLASSIFICATION AND DIMENSIONALITY*

In the second chapter I discussed in detail the process of classification and the various issues surrounding the classification of mental disorders. As described therein, the DSM-IV uses a categorical system based on a probabilistic approach. According to the probabilistic view, categories are organised around prototypes or exemplars which typify the category by incorporating all of the essential features. Members of each category may have all or only a few of these features depending on to what extent they exemplify the prototype. In this sense categories and their boundaries are only loosely defined and members of categories may attain membership in a number of ways. For

instance, many mental disorders consist of symptom lists which may be variously manifest. For example, depression may be diagnosed if dysphoric mood or loss of interest occurs with any five of the other nine symptoms. So two people with the same diagnosis may have quite different symptom patterns and one person may be viewed as a more typical case than another with the same diagnosis.

While this approach may sound flexible it is important to note that in many ways it is not. Although some categories allow for different symptom configurations there are typically clear boundaries between disorder and non-disorder. For instance diagnostic categories usually specify the number of symptoms which is required for category membership and a duration threshold. In other words, diagnosis usually depends on an individual having x number of symptoms for x number of days, weeks, or months. In this sense the DSM-IV provides a clear marker for pathology. And also disorders are seen as distinct from one another; that is, there are clear boundaries between disorders. An individual is either one thing or another, or both, but not a bit of this and a bit of that; although as mentioned in chapter 2 there are some mixed categories in the DSM-IV.

Considering the obvious diversity of mental disorder world-wide the categorical approach with its underlying bio-medical model and related thesis of ubiquity is arguably inappropriate. Constructivism clearly favours a dimensional rather than a categorical approach to the understanding of psychopathology because it allows for the inclusion and analysis of more contextual-oriented and idiosyncratic information. Through its flexibility, a dimensional system can provide a more individualised profile of a person's condition. This is made possible by the use of continuums which are used to evaluate different types of psychopathology yielding values which describe the extent and severity of symptoms.

According to the dimensional view normality and abnormality lie on the same continuum and are hence seen as related, rather than as distinct and mutually exclusive groups. This means that mental illness is not an all-or-nothing phenomenon, but is instead something which can occur in varying degrees. Therefore, one of the primary goals of diagnosis would be, to ascertain the severity of a disorder rather than to decide whether or not a disorder is evident. So a person could be described as having mildly



depressive symptomatology which was not believed to require treatment, and there would be no need to decide whether or not the person's symptoms 'satisfied' diagnostic criteria of duration and severity. Admittedly, this type of diagnosis is sometimes carried out under the present categorical system, however it is often viewed as inferior, and as perhaps having less explanatory power, simply because the DSM-IV encourages the assumption that diagnoses should result in clear cut identification of categories and their prototypes.<sup>10</sup>

As well as the suggestion that mental illness lies on a continuum with mental well-being, the dimensional view proposes that some disorders may be linked to each other. For example, Kendell (1968) posited that neurotic and psychotic depressions might occur at opposing ends of the same behavioural or mental spectrum. A classification system of mental phenomena which incorporated this type of assumption would have no difficulty in accounting for symptoms which fall somewhere between these variables. Such a case would be given a rating designating the person's position on this scale, which would describe his or her predominantly neurotic or psychotic symptoms.

According to a constructivist perspective one of the primary advantages of a dimensional model of mental disorder is its holistic emphasis wherein a wide range of clinical features are considered in the formation of a comprehensive clinical picture. This picture allows for the inclusion of detailed information, with no one characteristic seen as more important than the others, as is the case with the categorical model (Millon, 1991). As noted by Millon this approach can deal more effectively with atypical phenomena. He states:

Dimensional profiles facilitate the assignment of unusual or atypical cases. In categorical formats odd or mixed conditions are often excluded because they fail to fit the prescribed criteria. Given the idiosyncratic character of many clinical conditions, a dimensional system permits representation and assignment of interesting and unique cases without forcing them into procrustean categories for which they are ill-suited (p. 254).

If persons from non-western ethnic or cultural groups are viewed simply as atypical cases, then the dimensional approach to classification might prove advantageous when

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<sup>10</sup> Although a probabilistic rather than a classical view is utilised, this is not explicitly stated, and what is predominantly evident within the DSMs is the utilisation of quite clear markers for the delineation of

a western system is used in the diagnosis of such persons. Rather than failing to meet any diagnostic criterion and hence potentially being excluded from a 'real' diagnosis, the person falling in the middle of a particular scale, would be described according to their rating on that scale and all that it signifies.

The typical diagnostic approach to psychopathology seems to stem from the classification system used in traditional medicine (Carson, 1991; Widiger, 1992) which of course deals with predominantly observable and discrete subject matter. Psychological data, on the other hand, are rather more elusive. However, even traditional medicine utilises some quantitative scales. For instance, even though blood pressure is often described as high, normal or low, the actual numerical value is also recorded (Gunderson, Links & Reich, 1991). It is believed that the numerical value carries information which is not entirely captured by these labels. If blood pressure was recorded simply as high, normal or low then obviously less information would be passed from one clinician to another and it may therefore be difficult for a physician unfamiliar with a patient to estimate the seriousness of that patient's condition.

Relatedly, in discussing the classification of personality disorders, Widiger (1992) notes that it is unlikely that there is a particular cut-off point, signifying pathology from non-pathology, which is constant across all individuals and all situations. As he explains, an estimation of the degree of maladaptiveness of an individual's dependency, should consider the person's "...social role...situational context...comorbid personality traits...and other variables" (p. 297). Using a dimensional system allows for the differential rating of individuals according to their own unique set of circumstances, rather than indiscriminately applying a predesignated norm.

Interestingly, although the categorical approach has again been used in the latest DSM, the dimensional model has wide support. In a review of relevant literature, Widiger reported that the vast majority of researchers favoured the dimensional model especially with regard to the analysis of personality disorders (Widiger, 1992). Despite this popularity however, the dimensional approach remains an attractive but underutilised proposition. Although there is agreement as to whether or not it should be

implemented there is little agreement on how this should be done. (Millon, 1991). Millon suggests that, furthermore, categorical systems can be used more swiftly in many situations allowing clinician's to diagnose more rapidly. Concentrating on a limited number of features, in terms of an all-or-none criterion may be seen to simplify the condition and render it more amenable to a speedy analysis. The categorical model also enables clear and straightforward communication about disorders, as it involves a standardisation of concepts and operational factors.

Proposing a synthesis of categorical and dimensional approaches, Nelson-Gray (1991) suggests that the prototypicality of diagnostic criteria be used to develop quantitative measures of pathology. This would involve a numerical estimation of the extent to which individuals exemplified each diagnostic criterion. In this way, as Nelson-Gray outlines, the DSM-IV could be adapted to include quantitative measures. Similarly, Skinner (1986) proposed a 'class-quantitative approach' which involves a synthesis of categorical and dimensional models. Such a synthesis would perhaps be a logical first step towards the use of dimensional approaches, and one which would not involve major changes to traditional diagnostic practices. And it would also avoid the problem of deciding what dimensions should be utilised. This issue on which there has been substantial disagreement, has been identified as one of the main obstacles to the implementation of dimensional models (Millon, 1991). For example, Eysenck (1960) suggested that three dimensions are required while Cattell (1965) proposed that at least thirty three are needed.

Presenting a powerful argument in favour of a dimensional approach Buck (1990) is highly critical of contemporary diagnostic practices primarily because they focus on only a narrow range of individual measures. And typically these measures reflect negative aspects of psychological functioning; that is they depict deficiencies and inadequacies. Consistent with a constructivist metatheory, Buck favours a more holistic approach which includes the acknowledgement of strengths as well as weaknesses. As she astutely notes, traditional diagnostic systems often result in the ascription of labels which are equated with the 'total person' and that this seeks to diminish and devalue areas of ability and strength. Buck sees mental disorder as falling on a continuum ranging from maladaptive to successful, rather than delineating a phenomenon qualitatively different from that experienced and displayed by 'normal' people.

Discussing the strengths of those who are diagnosed with a mental disorder Buck gives this example of the poetry of a frequently hospitalised man who had been diagnosed with schizophrenia. She describes him as relatively uneducated and with no prior tuition in writing poetry.

## *In Praise of Poetry*

*How it changes the seasons and the stars,  
How it names things  
                giving them meaning...  
How it multiplies  
                wonder  
                and majesty  
and metaphor.  
How it elevates the soul  
How it penetrates below the surface  
                where the power is...  
How it gives instant joy to both  
                writer and reader.  
How it sometimes is more real  
                than reality,  
                bigger than life.  
How in poetry  
                everything is possible...  
...when poetry speaks,  
                people listen  
and things happen.*

This sort of creative ability is not uncommon in individuals diagnosed with conditions such as schizophrenia and autism (Sacks, 1995). A number of theorists have linked such cases to the modularity of the mind (e.g. Gardner, 1993; Smith & Tsimpli, 1995). According to Gardner's well known and increasingly well regarded theory of 'multiple intelligences', intelligence is not a unitary phenomenon as assumed by traditional evaluative methods. Rather there are a number of quite different and distinct intelligences - such as musical, linguistic, and logical-mathematical - which can function quite independently of one another. As suggested by Gardner, a modular understanding of intelligence provides an explanation of the occurrence of one or more talents coupled with problems in mental functioning in other areas.

Relatedly, Goodwin and Redfield Jamison (1990) in their comprehensive study of manic-depressive illness, discuss the connection between mood disorders and human

achievement. Taking issue with the traditional clinical focus on pathology they write: "...a psychopathological approach to mood disorders has resulted in a psychiatric literature generally slighting the positive aspects of affective illness, especially manic-depressive illness and its variants" (p. 332). Looking at the relationship between manic-depression and creativity, the authors present an impressive number of individual cases, including such notable figures as Lord Byron, Virginia Woolf, and Schumann all of whom appear to have suffered from manic-depressive illness. They include at the outset this statement by Tchaikovsky (1872): "Schumann's greatness on the one hand lies in the depth of his spiritual experience and his striking originality...With the shadow of his insanity already hanging over him, this inspired poet of human suffering seemed incapable of finding moments of tranquility" (p. 332). Looking in detail at Schumann's illness over time and his periods of productivity as a composer, it is apparent that the times when he would have been described as hypomanic, were his most productive. Goodwin and Redfield Jamison note that this pattern of creativity is consistent across many diverse cases suggesting that the inflated confidence, heightened sensitivity to external stimuli and the ready flow of ideas may enhance artistic functioning.

It is Buck's view that traditional diagnostic practices undermine such positive aspects of mental disturbance by focusing too heavily on areas of disability or abnormality. She suggests that ideally "...each person would be assessed in terms of the degree of interpersonal, creative and intellectual competence demonstrated with the expectation that weakness in one area is not inevitably connected with failure in all" (p. 187). Such an assessment, she proposes, would avoid the use of labels and instead evaluate various dimensions of existence along a continuum. These dimensions might include such areas as autonomy, identity and work. The primary advantage of this approach is that the assessment process would acknowledge people's strengths as well as their weaknesses rather than simply describing a person in terms of one or other essentially negative label.

An in depth analysis of the merit of dimensional approaches to the understanding of psychopathology is beyond the scope of this dissertation. Clearly it is a complex issue requiring further investigation before any firm conclusions can be drawn. However according to a constructivist metatheory, a dimensional model is superior because it enables a more detailed and individualised diagnosis which can deal more effectively

with contextual variables. And in this way a dimensional classificatory model would better serve the diversity of mental disorder and cultural diversity in particular. A dimensional approach to the construal of mental disorders may be particularly appropriate for cross-cultural diagnoses, insofar as ethnic and cultural differences can be accurately understood as simply atypical instances. A dimensional view allows for a greater scope of knowledge acquisition which inevitably enables a more thorough analysis of contextual information which is especially important in cross-cultural diagnoses.

### *ADDRESSING CONTEXT IN DIAGNOSIS*

Discussing the 'contextual nature of psychiatric diagnosis' Rosenhan (1975) reflects on his well known experiment involving the admission of 'pseudo patients' into psychiatric hospitals. The patients, all of whom pretended, at initial assessment, that they were having or had had auditory hallucinations, reverted to normal behaviour on admission to various institutions. However despite the absence of any other abnormality all patients were diagnosed initially and at discharge with either schizophrenia or manic depressive psychosis. Rosenhan's primary argument is that the context of behaviour colours psychiatric diagnosis. Because the pseudopatients were evaluated in the context of a psychiatric hospital they appeared more psychologically disordered. According to Rosenhan all stimuli may be influenced by context but some more so than others. Context is particularly important when stimuli are ambiguous as demonstrated by this example from visual perception (see *figure 4*).

According to Rosenhan, most people read the top two words as THE CAT even though the two middle letters in both words are identical. In contrast the bottom line is typically viewed as containing a spelling error. This demonstrates the importance of context in visual perception. Analogously, the data of diagnosis may be interpreted differently depending on contextual factors. Illness inevitably occurs in a context, socio-cultural or otherwise, the understanding of which is important for accurate diagnosis. According to a constructivist position the context of disorder impacts not only on the diagnosis but also on the disorder itself. Hence diagnosis and treatment will

necessarily involve an understanding of context and interventions which address it, as outlined below.

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THE CAT

THE CAT

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Figure 4. The influence of context on visual perception.<sup>11</sup>

The data gathered in the process of formulating a DSM-style diagnosis are drawn from a limited domain of information (Poland, Eckardt & Spalding, 1996). Assessing the signs and symptoms of diagnostic categories typically involves observation of an individual in a clinical setting, self report, third party interviews and various longitudinal and historical analyses; for example, family history and duration of symptoms. Poland and colleagues contest the quality of such limited data and claim that the emphasis on pathology comes at the expense of a balanced view of individual functioning. They argue that the DSM approach fails to acknowledge the context of mental disorder and the 'massive' heterogeneity of individuals who receive the same diagnostic label. They write: "...a DSM-oriented diagnostic assessment does not produce adequate information on clinically important features of the individuals it classifies" and "...a DSM-oriented assessment leaves the clinician in a weak position for effectively saying what is wrong with a given person, what is likely to be most effective in helping him or her, and what is likely to happen over time" (p. 250).

These criticisms are made not only with regard to the lack of contextual material in diagnosis but also with reference to theoretical issues such as the DSM's lack of conceptual precision. However it is the 'context' of diagnosis which I will discuss herein. Diagnosis using a manual such as the DSM involves the assessment of an individual according to certain criteria. Hence much idiographic information is

considered irrelevant. Poland et al. claim that this approach is problematic because it ultimately yields a one-sided interpretation of a person which is necessarily inaccurate because of its narrow, decontextualised focus. In response to such a claim one could argue that there is no alternative, for two reasons. Firstly it would be impossible to learn every detail of a person and secondly there needs to be some means of comparing clinically relevant data, as without such comparison it would be impossible to understand the phenomena. Very probably this is true however there may be alternative and superior approaches which take account of context without requiring a detailed account of one's life history and while still allowing communication of clinically significant information.

Sadler and Hulgus (1994) claim that "...the DSM-III-R diagnosis tends to make biological conceptualisations of the patient primary and the psychosocial secondary"<sup>12</sup> (p. 263). And "...having an acontextual diagnostic system perpetuates the hegemony of biological psychiatry" (p. 264). In support of this view they point out the biased approach of the DSM to the inclusion of explanations of etiology, which is supposedly dependent on scientific evidence. This is demonstrated by the fact that only biological etiologies are considered to have sufficient 'scientific' proof to warrant explanation in the manual. For instance Cannabis Delusional Disorder - which is subsumed under the class of Organic Mental Disorders - is traced etiologically to cannabis abuse. However in contrast 'functional' disorders are not considered to have sufficient evidence to afford the mention of etiology. However as argued by Sadler and Hulgus, a disorder such as Post-traumatic Stress Disorder (PTSD) has a very clear etiology. By definition it must be tied to a catastrophic life event. And the authors suggest, quite rightly I believe, that the evidence linking PTSD to a stressful life event must be, by now, rather substantial.

This, Sadler and Hulgus claim is evidence of a double standard: Cannabis is considered to be causal, while catastrophic life events are not. Accordingly they argue that the DSM-III-R is less concerned with psychosocial variables than with biological ones and that hence, it is unable to deal with contextual - personal, historical and cultural -

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<sup>11</sup> Copied from Rosenhan (1975, p. 464).

<sup>12</sup> This article was written prior to the publication of the DSM IV hence it refers throughout to the DSM-III-R. However I believe its ideas are equally relevant to the most recent manual.



information; such as inter-familial communication, life events, and occupational functioning. Such variables they claim may have profound effects on ‘etiology, treatment and prognosis’ yet they can not be included or even acknowledged by a DSM-III-R diagnosis. And this, the authors argue is a serious deficiency.

In response to this deficiency Sadler and Hulgus present a ‘nosology of context’ which may be used in conjunction with the DSM-III-R. Their proposal outlines a significant change to what is presently Axis IV. This axis allows for the evaluation of psychosocial and environmental factors which may have contributed, in some way, to the disorder. Sadler and Hulgus argue, in agreement with a number of other theorists (e.g. Williams, 1985a, 1985b; Mezzich, Fabrega & Mezzich, 1985) that in its present form Axis IV is too vague and non-specific to be clinically helpful, as it provides only a global or general assessment of socio-environmental stressors. Sadler and Hulgus suggest that what is needed is a ‘nosology of contextual syndromes’ which would enable a more accurate and detailed assessment of socio-environmental factors. In this regard they propose that contextual syndromes be divided into three general classes: “syndromes of personal history; of interpersonal environment; and of the extrapersonal environment” (p. 270). Figure 2 lists some examples of the syndromes which might be subsumed under each of these classes.

Syndromes of Personal History	Syndromes of the Interpersonal Environment	Syndromes of the Extrapersonal Environment
Early parental death	Violent victimisation	Catastrophe
Incest	Interpersonal	Homelessness
Childhood physical	over involvement	Loss of
abuse	Interpersonal	employment
Parental neglect in	underinvolvement	Socio-cultural
childhood	Divorce process	transplantation
Serial - extrafamilial	Family scapegoating	Cult influence
placement of childhood	Death of spouse	Media influence
and adolescence		
[Others]	[Others]	[Others]

*Figure 4. Sample diagnoses from each category of a nosology of context.*<sup>13</sup>

<sup>13</sup> This is an exact reproduction of the table provided in the aforementioned article.

The authors do not intend this as either a final or exhaustive list of possible contextual-centred syndromes. Rather it is meant as a 'working' example of a contextual nosology which they believe meets standards of parsimony in classification yet can also address the complexity of contextual information. They write, "...the proposal here is emphatically a compromise between the twin goals of holistic understanding of the patient and having a user friendly nosology" (p. 275). This approach is innovative in combining nomothetic and idiographic approaches to classification.<sup>14</sup> That is, they incorporate individual factors into the framework of a normative and categorical nosology. This novel approach is a good example of the way in which contemporary classification systems might be modified to include contextual information.

A constructivist approach to classification and diagnosis sees context as vital to the understanding of psychopathology. This is in part due to the socio-cultural embeddedness of meaning and in part to the significance of context per se. Constructivism assumes that the personal and interpersonal meaning of disorder is inextricably tied to social factors such as language and customs which may not be included in a typical diagnostic situation. Such factors are particularly important in cross-cultural contexts, especially when clinician and client are from different cultural backgrounds; because as I have attempted to demonstrate in previous chapters and as Ahia (1991) points out: "Clinical features themselves have not been found to be impenetrable by socio-cultural indices or differences" (p. 38). Ahia states that the use of normative diagnostic tools such as the DSM series is problematic with individuals who fall outside the range of the norm group, in relation to which, the manual was developed; for instance those with non-western socio-cultural backgrounds.

Ahia makes these comments prior to the publication of the DSM-IV which, as revealed earlier, has been modified to enhance its cross-cultural applicability. But arguably the criticisms are still relevant and persuasive as the DSM-IV has retained its bio-medical, universalist underpinnings. Ahia's statement above captures the heart of the problem: that clinical features vary across cultures and hence the various symptom configurations

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<sup>14</sup> These terms were coined by Wilhelm Windelband to describe two alternative approaches to science (Sadler & Hulgus, 1994). Nomothetic science describes objects and events in terms of general laws, whereas idiographic science describes in terms of the particulars of the objects and events themselves.

in the DSM may not be trans-culturally applicable. And Ahia notes also that it is the clinical features - namely symptoms - which form the back-bone of the DSM, not theories of etiology or underlying mechanisms. Addressing the need for more culture-sensitive diagnostic techniques - especially in the treatment of immigrants - Ahia suggests three main methods for fostering an understanding of context, to be used as an alternative to DSM-style approaches or in conjunction with them. He calls these social interpersonal analyses, comparative behavioural and environmental analyses and consultation.

Social interpersonal analysis involves an open-ended and unstructured investigation of an individual's psycho-social history with particular focus on those factors which appear to be related to the presenting problem. What is important here is how the client perceives the problem in relation to his or her cultural background. Comparative behavioural and environmental analysis involves the evaluation of different levels of adjustment. Many people who settle in countries with cultures which are radically different from their own, find the process of adjustment difficult and often stressful, leading to psychological problems. Such problems might be wrongly diagnosed if the issue of adjustment is overlooked. The last method suggested by Ahia is consultation, which refers to the need to at times obtain information from professionals who are knowledgeable about the language and practices of particular cultures, as often clinicians lack the cultural information to fully understand the problems of some clients.

Ahia's social interpersonal analysis would be a useful addition to other more traditional diagnostic tools such as the DSM. It provides a systematic means of incorporating and evaluating socio-cultural variables in diagnosis and hence facilitates the development of an understanding of the impact of culture on the manifestation of psychopathology. As argued in previous chapters this impact is important not only in terms of its contribution to the initial presentation of the disorder but also its course and outcome. Therefore a greater understanding of these complex influences at the outset will allow the development of more appropriate and consequently, more effective treatment.

## *CULTURE-SENSITIVE TREATMENT*

A constructivist definition of mental disorder also has important implications for treatment. In particular, as in diagnosis, context and meaning are two dimensions of psychopathology that need to be addressed. If a mental disorder has a significant socio-cultural dimension, this dimension needs to be considered in the planning and implementation of treatment strategies. This approach can be seen in contemporary practice in the use of family interventions, which focus not only on the individual concerned but also on their familial relationships and any problems which may lie therein. Such an approach may be particularly useful in cross-cultural contexts in which familial factors may be especially influential. This is highlighted in the following study carried out in Ecuador.

This study by Price (1992) demonstrates the role of socio-cultural factors in the response to serious illness. Describing in detail two cases in Ecuador of peoples' meaning-making responses to affliction and loss, the author notes the importance of cultural and especially familial context in psychological coping.<sup>15</sup> He proposes that "...meaning based coping constitutes a pivotal factor in adaptation to misfortune for many individuals and families" (p. 153). Essentially what is being referred to here is the need for individuals to interpret and integrate experiences according to their own belief systems. Price states: "For many individuals and families, cultural meaning traditions enhance self-esteem and preserve a sense that those involved can affect the outcome of the illness situation" (p. 154). This sense of understanding and control enables more positive outcomes wherein individuals demonstrate greater acceptance of their situation and an enhanced ability to deal with it.

As discussed earlier familial interpersonal relationships are particularly important in the course of schizophrenia. Lam, Chan & Leff (1995) provide a detailed account of their psycho-educational familial approach in the treatment of a young immigrant Chinese man diagnosed with schizophrenia. This approach placed a strong emphasis on the acknowledgement and understanding of cultural variables in the development and implementation of treatment. This was done through group sessions, conducted in

Cantonese, which encouraged each family member to express his or her views, giving the clinician insight into culture-centred issues. A number of important issues were identified, including: fear of losing face, overprotectiveness of the parents and the perceived loss of status for the family. The clinicians focused on assisting Peter (the patient) to become more independent, and on fostering more positive opinions of Peter among other family members alongwith providing general information on schizophrenia. The treatment programme proved successful. At follow-up Peter had been symptom free for one year.

This is just one example of how the treatment of a major mental disorder can be tailored to meet the needs of individuals who come from different cultural backgrounds. It is unlikely that a pharmacological intervention which took no account of the context of Peter's illness would have been as effective. Inter-familial relationships appeared to be one of the stressors which contributed to the manifestation of Peter's symptoms hence addressing these had major benefits for him. One of the primary aims of the clinicians was to identify and understand what the illness meant to Peter and his family, as the meaning of illness seems to form an important part of its course; that is the various interpretations and connotations of the disorder invoked by both Peter and his family, influenced the way that he experienced and expressed his symptomatology.

## SUMMARY

As shown in this chapter, a constructivist definition of mental disorder has important implications for classification, diagnosis and treatment. The multi-faceted nature of a constructivist conceptualisation demands a number of substantial modifications and alternatives, to traditional techniques. A dimensional approach appears to be the best way of incorporating a constructivist philosophy in classification because, through their inherent flexibility, dimensional systems are necessarily more sensitive to both individual and socio-cultural variables. Accordingly I have discussed some of the advantages of dimensional nosologies over traditional categorical classification systems and introduced some of the arguments in favour of these.

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<sup>15</sup> It is not possible to provide detail of these case studies here. If this is of interest refer to the

With regard to diagnosis, a constructivist approach requires the incorporation of factors such as meaning and context which are not always fully considered in contemporary diagnostic manuals. As shown, there are a number ways of adapting diagnostic manuals such as the DSM-IV which would enhance their capacity to acknowledge and respond to these variables. Of particular importance here, is the suggestion that some of these methods may be used in conjunction with the DSM-IV, allowing the capacity for greater depth and detail in diagnosis. And a constructivist understanding of mental disorder also has implications for treatment. I outlined just one of these, namely family interventions, which is particularly useful in cross-cultural contexts. The following chapter looks at implications for research.

## CHAPTER 10

# RESEARCH IMPLICATIONS AND THEORY EVALUATION

This chapter begins with a discussion of the implications of a constructivist approach for research on psychopathology. This discussion focuses on two main implications, each of which is addressed by way of a proposed alternative research methodology. The first of these is the need to acknowledge the heterogeneous nature of mental disorders. A diagnostic label such as schizophrenia can refer to a diverse mix of individuals with various symptom configurations. Yet many studies fail to control for this diversity and present findings which are claimed to represent a single homogenous group. According to the constructivist definition presented earlier, this investigative approach is problematic because it relies on a very general understanding of mental disorder which ignores individual differences. People may be considered diagnostically equivalent on the basis of only a small degree of commonality (and some individuals will have no symptoms in common) however many studies of mental disorder fail to address this issue. In line with the constructivist emphasis on individual differences and research programmes should ideally address the issue of heterogeneity of psychopathology.

The other main implication for research is the requirement that methodologies take account of contextual information. The constructivist definition of mental disorder outlined earlier, has a significant socio-cultural component which assumes that many syndromes are to some extent contextually embedded. According to this view research should attempt to understand mental disorders within the contexts that they occur rather than treating them as isolated entities. If familial and other social variables are believed to play a role in the manifestation and course of various disorders then these variables need to be addressed in research methodologies.

The second part of this chapter evaluates the constructivist understanding of mental disorder which I have presented including a short section addressing the limitations of this approach.

## *IMPLICATIONS FOR RESEARCH*

There are a number of research related problems with the DSM approach to classification (Poland et al., 1996). These include the polythetic nature of its category structure which allows for enormous heterogeneity of clinical attributes and underlying processes. And the pseudoscientific status of many of its concepts, which are a combination of lay-notions and traditional psychiatric terms. As argued by Poland and colleagues, these category characteristics result in a wide array of potential confounding variables and subsequent high likelihood of experimental error. For example, a person may be diagnosed with schizophrenia if they have any two (or more) of five symptoms. So, one patient could receive a diagnosis of schizophrenia based on the presence of delusions and disorganised speech while another with the same diagnosis may exhibit disorganised or catatonic behaviour coupled with negative symptoms. Many other DSM categories allow for similar degrees of heterogeneity. For instance there are 93 different ways of satisfying the criteria for a DSM diagnosis of borderline personality disorder (Widiger, 1992).

Discussing this within category diversity, Poland et al. write: "To the extent that this sort of variability is not measured and taken into account, the results of such research are uninterpretable and of questionable value (p.251). The central issue here is whether the many diverse presentations of say, schizophrenia are in fact the signs of one syndrome, or many more narrowly manifest ones. If the latter is the more accurate representation then research could be seriously hindered by the use of incumbent categories. Interestingly it is widely acknowledged that the validity of most DSM syndromes is poor (e.g. Poland et al., 1996; Carson, 1991) and yet many research projects base their methodologies on the existence of these syndromes. Apart from the heterogeneity of the various conditions, as noted by Poland and others there is another reason also why a DSM-oriented approach to research is problematic; namely the context dependence of symptom presentation.



Clinical symptoms do not, and can not, occur in isolation from other personal characteristics and phenomena. They are interrelated with physiological, psychological and various external situational factors. Brain processes typically involve a complex interaction of locale and function which evades explanation in terms of one area or one level of activity. This complex mental milieu is realised in a number of ways, including the multifarious expression of cognition and emotion. In other words, pathology is mediated by and dependent upon the interaction of intra-individual and extra-individual factors which lead to differences in patterns of symptomatology. Arguably the failure to consider these factors in investigations of psychopathology provides a window for error, at least insofar as they may be considered extraneous variables.

According to a constructivist approach to the understanding of mental disorder, research programs should address both of these issues. That is, they should acknowledge the heterogeneous nature of most diagnoses and they should take account of contextual information. Importantly, the meeting of these expectations would greatly enhance the efficacy of cross-cultural research programmes. As explained through the definition and model presented earlier, constructivism sees mental disorder as a many-faceted phenomenon with several interconnected etiological components. Hence a constructivist approach to the study of mental disorder will require the implementation of methodologies which reflect this complexity of manifestation and diversity of origin. A constructivist metatheory requires also that the mutability of understanding be acknowledged. No theory should be taken as the last word or ultimate explanation of certain phenomena. As in science generally, the history of understanding and explanation of psychopathology shows many dramatic turning points, at which old ideas were demonstrated to be inadequate and were hence superseded by better ones. Research can promote such advancement (if one can be so bold as to assume that this is indeed what it demonstrates) by encouraging the creation and use of falsifiable theories thereby strengthening the links between theoretical and empirical arenas.

Returning to the issue of the heterogeneity of mental disorder, the approach of Persons (1986) to the study of psychopathology may prove advantageous. Persons argues that research should investigate psychological phenomena rather than diagnostic categories. She states that "...research efforts to understand the nature of the psychological

processes underlying such psychological phenomena as formal thought disorder, delusions, and hallucinations will be more successful if the phenomena themselves are studied directly than if diagnostic categories (e.g. schizophrenia ) are studied (p. 1252). According to Persons, most studies of thought disorder involve the comparison of schizophrenic and nonschizophrenic individuals in terms of theorised psychological processes. She suggests that this could be dubbed the “diagnostic category” investigatory method. As argued above, this method is problematic as it blurs the distinction between the various manifestations across individuals who have the same diagnosis. Using this method many different symptom configurations are lumped together under the one umbrella based on the assumption that there is a unifying factor at some level of explanation. This may confound results through the misgrouping of phenomena and hence through the introduction of uncontrolled variables.

For instance, a diagnosis of schizophrenia does not require the presence of thought disorder and even those who do have this symptom typically fluctuate between periods of incoherence and lucidity. Yet most studies of thought disorder simply compare schizophrenic and nonschizophrenic individuals without reference to the presence of thought disorder at the time of inquiry. Moreover, as Persons points out, there are other diagnostic categories which may also exhibit thought disorder, for example, bipolar affective disorder. Hence a study comparing schizophrenic and nonschizophrenic individuals is not therefore a study comparing those with and without thought disorder as some researchers assume. Persons describes this as a problem of misclassification, which she argues would be avoided if thought disorder was studied directly without reference to particular diagnostic categories.

As noted by Persons another important advantage of the symptom-oriented approach to research is the facilitation of theoretical understanding. As the object of inquiry is broken down into smaller units it is easier to tie these units to particular mechanisms. It is easier for example to determine the mechanism underlying hallucinations than it is to determine the mechanism(s) underlying schizophrenia. Bannister (1968) stated that schizophrenia involves “...a multiplicity of behavioural criteria, and the attempt to link it directly with a specific biochemical agent leaves, between the two, an enormous gap” (p. 185). The symptom based approach makes the task of detecting underlying mechanisms easier by narrowing the breadth of the enquiry and looking at symptoms in

isolation from one another. Yet it can also allow for the examination of the relationships between symptoms thereby promoting the understanding of symptom configurations within syndromes.

According to constructivism, a symptom-based approach to the study of mental disorder is advantageous because it can more easily incorporate and account for heterogeneity. Such an approach may be particularly appropriate in the area of cross-cultural psychology where it is more likely that there will be syndromal differences. The study of symptoms may seek to identify these differences rather than overlook them in the process of generalisation. For example, the core symptom configuration of schizophrenia which has been widely used in the cross-cultural study of schizophrenia is aimed at the identification of a fixed number and type of symptoms to the exclusion of all other phenomena. If in this case symptoms were studied rather than the syndrome of schizophrenia, it would be possible to determine in what way the various symptoms differed across cultures which would further the understanding of culture-specific presentations. Research at the level of symptoms allows for the gathering of more information and hence greater accuracy.

Looking now at one means of addressing the context of disorder in research, Kleinman (1992) outlines an ethnographic method for the study of health and illness across cultures. He states that "...ethnographic methodology means describing a particular social context and interpreting within it places, people, and other meaningful things" (p. 127). He points out that while such an approach may seem "obvious and sensible" it is not the way that research in clinical areas is traditionally conducted. The traditional approach more closely resembles the core symptom approach outlined above which focuses on the presentation of universal forms of pathology. In contrast ethnographic method focuses on what Kleinman refers to as the 'local world' which is essentially the socio-cultural context of experience. He sees experience not as entirely subjective and personal but as 'intersubjective' and 'interpersonal'. He states that "...experience should be seen as a flow, a medium moving between and within persons that is the condition for, as well as the achievement of, actions and transactions" (p. 128). Kleinman proposes also that experience should be understood and interpreted according local morality. He wants to emphasise here, that local worlds consist of the beliefs and values that mediate and direct people's lives.

Kleinman claims that local worlds powerfully influence human illness and suffering and hence he proposes that in order to understand these phenomena it is necessary to firstly become acquainted with the local worlds in which they occur. He states, "...suffering needs to be described and interpreted as part of the lived flow of interpersonal experience in local moral worlds" (p. 129). Central then to this approach is the social dimension of human existence which Kleinman sees as profoundly influential in the manifestation of illness. It is his view that research methods within medicine typically have a very narrow and superficial focus which excludes socio-environmental variables and results in a comparatively small and limited data base. In contrast an ethnographic methodology demands a detailed and wide-ranging analysis with the aim of permeating and ultimately understanding another culture. Ideally this should be done with as much objectivity as possible. In other words the various aspects of the social world which is to be investigated should be analysed in relation to each other rather than compared to external measures. This process is based on the assumption that there are subtle yet deeply rooted interconnections between individuals and their beliefs, traditions and institutions and that an understanding of culture is dependent on an understanding of these interconnections.

While Kleinman proposes that this ethnographic method be used for general medical research, it would be especially useful in the field of psychopathology wherein the social context of experience and behaviour is particularly important. Studies which utilise a methodology which centres around the imposition of Western conceptions on alternative understandings, risk the misinterpretation of data through the general disregard for context. Kleinman (1988) refers to this bias - of classifying illness in one culture according to the diagnostic categories of another (without prior testing of their cross-cultural validity) - as the 'category fallacy'. Such studies also have a limited capacity for attending to and reporting on the tremendous depth and complexity of socio-cultural data. Ethnographic approaches could be combined with the more commonplace universalist style studies yielding research methodologies which have the capacity to discover both cross-cultural similarity and diversity. A composite approach of this sort, which combines traditional medical and anthropological research methods is recommended by Lewis-Fernandez and Kleinman (1995).

## *EVALUATION OF A CONSTRUCTIVIST APPROACH TO THE UNDERSTANDING OF MENTAL DISORDER*

The various suggestions and recommendations outlined above demonstrate the value and utility of a constructivist metatheory in the field of cross-cultural psychology. Constructivism provides a number of interesting avenues for the development of both theoretical and empirical research programmes in this area. Obviously most, if not all, of these proposals are relatively novel and only superficially explicated, however they nonetheless show that constructivism has much to offer the field both as a theoretical framework for conceptual understanding and a guide for the modification and improvement of clinical and research methodologies. From the definition and classification of mental disorder to treatment and research, constructivism provides a guide for the facilitation and development of more culture-sensitive and hence more cross-culturally appropriate approaches.

I want to emphasise here the importance of theory within psychology and within science generally. As argued by Howard (1985), understanding within science is dependent on theoretical knowledge because empirical data may support a number of incommensurable theories. And moreover scientific observations are always dependent on theoretical understanding (Chalmers, 1976). So-called hard data are observed and interpreted according to a particular theoretical position. Typically empirical research is carried out in order to test a theory - to confirm or disconfirm it. However as noted by Howard competing theories are not evaluated simply through scrutiny of the "brute facts", but rather through an analysis and comparison of the theories themselves. This process of analysis which is referred to as theory appraisal or theory evaluation, has been widely discussed within the philosophy of science. Central to this discussion is the question of what makes one theory better than another. If it is not simply a matter of evaluating the data of observation then there must be some other important criteria.

I am going to discuss in detail, Kuhn's views on these matters because they have been, since their inception, influential, and because they are probably the most widely accepted. Kuhn (1977) suggests that there are five main criteria which are important in the evaluation of theories: accuracy, consistency, scope, simplicity and fruitfulness.

Accuracy refers to the rather obvious requirement that theories accurately describe and predict the phenomena which they seek to explain. Consistency proposes that all aspects of the theory should be consistent with one another and that the theory is consistent with other accepted theories in the same field and in science generally.<sup>16</sup> Scope refers to the criterion of broad application, meaning that the theory should have wide-ranging consequences, extending beyond the limited area to which it originally pertained. Very similar to this notion, and yet I think distinguishable from it, is what Howard (1985) terms unifying power, which he defines as 'the ability to bring together' previously unrelated and divergent aspects of knowledge. Also similar is the concept of explanatory breadth which to Thagard (1992) is quite simply the capacity to explain more phenomena. Simplicity describes the requirement that a theory brings order to otherwise arbitrary or inextricable phenomena and also that it does so parsimoniously. And lastly fruitfulness, which has also been referred to as fertility (Howard, 1985), proposes that a good theory is one that facilitates the development of research programmes and hence leads to new discoveries.

I will now evaluate constructivism according to each of these criteria in turn. It should be noted that constructivism is best conceived of as a metatheory rather than a theory per se, because it is a general perspective which may be applied to a number of different fields. For instance it has implications for epistemology on the one hand and clinical psychology on the other. Put simply a metatheory is a theory about a theory. In other words a metatheory is similar to a research program (as referred to by Lakatos, 1974) and a paradigm (As referred to by Kuhn, 1977) or it might also be described as a global theory.

Firstly accuracy, which might perhaps be considered the most important - even if in all other respects a theory is satisfactory or even excellent, it is utterly worthless if it is inaccurate. A constructivist understanding of mental disorder is a more accurate representation of the relevant phenomena than the traditional biomedical approach. Research findings indicate that there is a significant interplay between physiological and socio-cultural forces. Constructivism, with its equal emphasis on, and interactive conception of, these dimensions, provides a more accurate account of mental disorder

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<sup>16</sup> Howard refers to these two criteria as internal coherence and external consistency, respectively.

world-wide. This accuracy is in part a product of constructivism's inherent flexibility which allows it to incorporate diverse phenomena. For example the definition of mental disorder proposed earlier, allows for varying etiologies depending on the nature of specific disorders. Considering the apparent heterogeneity of psychopathology across cultures and the complex array of causal factors, this constructivist definition provides, particularly by way of its mutability, an accurate analysis of the relevant phenomena.

Secondly, constructivism also meets the criterion of consistency which has two quite different aspects: internal and external. The theory is internally coherent in that no element is incompatible with any other. From its application in a definition of mental disorder through to its use in the development of research methodologies, it is in all respects consistent with itself. And it also demonstrates external consistency - that is, it is compatible with other theoretical and empirical approaches. As noted in the previous chapter a constructivist definition of mental disorder is consistent with a number of other theoretical perspectives and as shown in this chapter it is compatible with some clinical approaches. Broadly speaking constructivism is consistent with conceptions and methodologies within anthropology, and within psychology it can be likened to what Littlewood refers to as the new trans-cultural psychiatry. Obviously the constructivist ideas which I have outlined are not consistent with the traditional bio-medical view of mental disorder as it is intended to challenge this, however there are nonetheless some areas of commonality. For instance constructivism also acknowledges that biology plays a role in mental disorder - but the extent and nature of this role is differently interpreted.

The third criterion for discussion is scope or explanatory breadth which refers to the capacity for bringing together or including a broad array of diverse and even disparate phenomena. Compared to the bio-medical universalist understanding of mental disorder, constructivism can account for more data. Specifically it can explain and incorporate the cross-cultural findings which demonstrate marked differences across socio-cultural groups. It also brings together what might otherwise be seen as distinct and unrelated phenomena in that it involves a synthesis of physiological and socio-environmental variables, with emphasis on the important interaction between them. Basically, constructivism can explain more of the data within the field to which it has

been applied. This is data which would have been anomalous according to the traditional purely biological explication of mental disorder.

Fourthly, constructivism also shows simplicity in that it bestows order on what are otherwise inextricable data. Research in cross-cultural manifestation of mental disorder reveals both similarities and differences between various ethnic and social groups, suggesting that there are probably multiple etiologies and numerous variables which impact on its manifestation. Through the application of a constructivist view some degree of order is evident in these findings - they are no longer incomprehensible. And moreover constructivism is parsimonious in that it is a clear and concise theory with a small number of central tenets. This criterion is often connected with explanatory breadth forming the condition that a good theory explains a wide array of data with the least possible amount of general laws or propositions. Basically, the more parsimonious the theory and the broader its application then the better it is.

The fifth and last of Kuhn's criteria is fruitfulness or fertility which is essentially a measure of the contribution of the theory to future research. Ideally a theory should contribute to the development of research programmes leading to new and important findings. As shown in this final chapter constructivism proposes a number of innovative research techniques including Person's symptoms-based approach and Kleinman's ethnographic method. These techniques are just a few of the many ways in which constructivism can contribute to the development of more culture-sensitive clinical practice and research methods. Obviously it was not possible to explore all of these avenues however the ideas which have been presented indicate the diverse and wide-ranging application of constructivism in these areas. Constructivism has much to offer both theoretical and empirical research through its alternative definition of mental disorder and its broader more pragmatic application within clinical psychology.

Maxwell (1984) proposes that another important criterion used in the evaluation of theory is value. In Maxwell's view intellectual inquiry should aid human kind in dealing with the problems of existence and in determining what is most important in life. So science should have general benefit for humanity, providing solutions to existential questions and providing guidance for dealing with day to day issues. While the notion of value may not at first glance have much to do with science, on inspection



it clearly plays a crucial role. For example consider the vast amount of time and money which is devoted to developing treatments for cancer. There is no doubt a plethora of research projects which are aimed at the discovery of cures for this disease. According to Maxwell these research projects are justified by the potential benefits which they offer - it is in this sense that they are valued. Arguably constructivism may be seen as valuable in that it has the capacity to enable and foster greater understanding of diversity. Rather than imposing a Western framework on all of human experience and human behaviour, constructivism encourages the development of alternative philosophies with the goal of a more rich and sophisticated understanding of human kind. This would be beneficial for all concerned but particularly for non-Western groups who are more likely to have their beliefs and values acknowledged and respected by researchers.

### *Limitations*

The constructivist definition of mental disorder which I have presented may be criticised on the grounds that it lacks detail and perhaps precision. Essentially I have proposed that a mental disorder is a breakdown in a complex system of interconnected variables with different components of the system playing a more important role in different disorders. At the centre of this system is the 'self' – the active processor and interpreter of events and experience – which imposes upon this system a degree of uniqueness. Hence there will be individual variation in the manifestation of mental disorder. Similarly, as there is a social component, psychopathology will vary across socio-cultural environments. In this sense there is no 'core' of disorder as there is according to the bio-medical model. A mental disorder is seen rather as a phenomenon with unclear boundaries which responds to changes in social value.

One might argue that acknowledging social factors to the extent that this characterisation suggests is appropriate, renders a rather unscientific account of mental disorder. To understand this criticism it is helpful to look again at Wakefield's approach to the definition of mental disorder. It was detail and precision that Wakefield hoped to add to definitions such as those found in the DSM-IV, which also relied on the concept of dysfunction to sharpen the boundary between normality and abnormality.

According to Wakefield the DSM's use of the concept of dysfunction did little to sharpen this boundary because it failed to explicate the concept. In response to this perceived deficiency in the definition, Wakefield provided an evolutionary explanation which centred on the notion of adaptive function. The primary reason for this explanation was to enable a more scientific and precise account of mental disorder.

According to this view, for a phenomenon to be a genuine mental disorder it must involve the breakdown of psychological mechanisms. This is the heart of problem; the crux of the matter; the core of disorder. And moreover Wakefield provided a way of establishing normal from abnormal function; namely adaptation. While there are a number of important problems associated with this approach one can appreciate its purpose - to add precision to an otherwise imprecise understanding. One could argue that the constructivist account which has been presented fails on the grounds that it provides no definitive marker for abnormality. There is not necessarily any natural counterpart for each disorder as some disorders are delineated primarily by social value. While this may seem problematic it is also unavoidable because, as argued, mental disorders are by their very nature imprecise and a definition of a phenomenon must reflect the phenomenon in question.

Relatedly it may be argued that a strongly social definition of mental disorder may be used to manipulate individuals. Disorders may be socially embedded leaving abnormality in the hands of socially ascribed value. Some might see this as a dangerous and therefore unsatisfactory position in that the delineation of disorders may be used for purposes of social control. In response to such a criticism I would argue that the definition I have proposed is simply describing the relevant phenomena accurately, and is not therefore encouraging the misuse of labels of psychopathology. It is rather like providing a definition of a word in a dictionary. There may be a strict original meaning which for some reason is considered favourable, however if one is to perform the lexicographers task effectively one must include all of the various definitions which have at one time or another been used. It is a rather loose analogy but a nonetheless effective one. A definition of mental disorder must accurately describe the phenomenon in question whether or not that definition proves to be acceptable on other grounds.

## *SUMMARY*

In this final chapter I have critically evaluated the proposed constructivist definition of mental disorder and have argued that it has a number of important strengths. However I do not see it as a grand or sole approach to the understanding of mental disorder. Rather, I view it as a stimulant or catalyst for developing new directions within the field of cross-cultural psychology and perhaps psychology as a whole. As noted and discussed by Howard (1985), as a science, psychology has some unique facets, most important being the agency of the object of study. This agency has both individual and social characteristics which impinge significantly on behaviour. In my view constructivism captures and explains these variables in a way that few theories can. This is its primary advantage and in this sense it is well suited to explanation within psychology.

## CONCLUSION

Mental disorder, like many other aspects of human experience and behaviour is a complex phenomenon involving a variety of diverse factors. One can conclude from the examination of the cross-cultural literature that the socio-cultural environment of human existence plays a particularly important role in the manifestation and course of mental disorder. However this dimension is not fully addressed by the traditional bio-medical view of mental disorder which continues to exert a significant influence on contemporary diagnostic manuals. While the DSM-IV has made some important modifications in the direction of cross-cultural understanding it nonetheless continues to utilise and uphold the bio-medical view which sees mental disorders as discrete entities which are often culturally immutable. This underlying philosophy is inconsistent with the superficial acknowledgement of social factors which if fully explicated would demand a quite different theoretical basis.

In response to this inconsistency and inadequacy I have offered an alternative understanding of mental disorder which I argue has a number of important advantages. In particular it exhibits greater explanatory breadth in that it can explain a wider and more diverse range of phenomena than the traditional view. The constructivist definition which I presented, provides a multidimensional understanding of psychopathology which allows for different types of mental disorder, acknowledging that there may be varying degrees of social and biological influence in different disorders. While some mental disorders are essentially the result of neurological degeneration others are dependent on socio-cultural variables. One of the central features of the proposed constructivist definition is that mental disorders are not seen as being adequately represented by one rigid set of characteristics but rather as varying combinations of several. And departing significantly from the bio-medical approach they are not seen as distinct entities with sharp boundaries but rather as conceptually mutable phenomena, the boundaries of which change with the vicissitudes of both social and scientific thought.

I discussed in the final two chapters the clinical implications of this alternative understanding of mental disorder. While many of the suggestions therein are rather underdeveloped and perhaps controversial they nonetheless demonstrate how change at the theoretical level can lead to changes in many other diverse areas. In developing a theory one must attend to empirical phenomena and likewise when a theory has been developed it is then tested through its application to the relevant phenomena. The test of a constructivist approach to the understanding of mental disorder will involve its application to all those areas which rely on and utilise this understanding. It should accurately predict phenomena; it should lead to the development of fruitful research programmes; and it should enable effective treatment. A theory can not exist in isolation from that which it seeks to explain. Rather, as Hempel suggested, there must be a continuous process of reciprocal interaction between theoretical and empirical analysis. Hence the constructivist approach to mental disorder must be explicated and tested through its application to various relevant domains.

Clearly such testing is beyond the scope of this thesis. While I have argued that my constructivist definition of mental disorder meets the numerous criteria for a 'good' theory, as with many novel theories, it must be subjected to the test of time. I propose though, that at this time, a constructivist definition of mental disorder provides a more satisfactory account of psychopathology than its rivals.

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